

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38001

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roy Harvey Hill, Sr.

2. Date of Death

Month Day Year  
NOVEMBER 27, 2000

3. Time of Death

4:07 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

223-32-7443

6. Sex

MALE 20 F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 22 1928

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 X Yes 2 0 No

10e. Street and Number

2938 Baetol Ave

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 0 Never Married 2 0 Married  
3 0 Widowed 4 0 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 0 Yes 2 0 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 0 Yes 2 0 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)  
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Joseph C. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Lavinia Booker

19a. Informant's Name/Relationship (Type, Print)

Deborah Dennis-Dough

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2938 Baetol Ave. Balt MD 21209

20a. Method of Disposition

1 X Burial 2 0 Cremation 3 0 Removal from State  
4 0 Donation 5 0 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans

Date

12/4/00

20c. Location - City or Town, State

Owings Mills MD

21. Signature of Funeral Service Licensee

► Flynn B. Harris

22. Name and Address of Facility

March Funeral Home West, Inc  
4300 Wabash Ave. Balt MD 21215

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic encephalopathy  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

Peripheral vascular disease

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 0 Yes 2 0 No 3 0 Probably 4 X Unknown

24a. Was an autopsy performed?

1 0 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 0 Yes 2 X No

25. Was case referred to medical examiner?

1 0 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 X Inpatient 2 0 ER/Outpatient 3 0 DOA Other: 4 0 Nursing Home 5 0 Residence 6 0 Other (Specify)

27. Manner of Death

1 X Natural 5 0 Pending investigation  
2 0 Accident 6 0 Could not be determined  
3 0 Suicide  
4 0 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 0 Yes 2 0 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 0 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Rolando Falcon M.D.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

November 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rolando Falcon 2401 W. Belvedere, Baltimore MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

► Bertha B Sparks

Patient known as: Hill Sr., Roy Harvey  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38002

HELEN  
HARGETTPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helen Virginia Hargett

2. Date of Death

Month Day Year  
NOVEMBER 28, 2000

3. Time of Death

5:28A.M.

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NONE

5. Social Security Number

217 28 1403

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 26, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5021 Durham Road West

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mehrl Austin Toms

18. Mother's Name (First, Middle, Maiden Surname)

Florence Virginia Shepley

19a. Informant's Name/Relationship (Type, Print)

Guy D. Hargett/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5021 Durham Road West Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resthaven Cemetery

Date

12-1-2000

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

▶ *Shawn A. Collins-Witzke*

MD 1044

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Multiorrgan System Failure*  
Due to (or as a consequence of):b. *Sepsis*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastc. *Toxic Epidermal Necrolysis*  
Due to (or as a consequence of):d. *Complicating therapy For Hip fracture*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?*Approval*1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

10/3/00

28b. Time of  
Injury

Unknown

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

*Subject Fell*28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)*Airport*28f. Location (Street and Number or Rural Route Number,  
City or Town, State)*Madrid, Spain*29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *J. Pestaner, M.D.*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH PESTANER M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

*Sparks*State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1871

1872

1873

1874

1875

1876

1877

1878

1879

1880

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38003

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oliver Fambro Horne

2. Date of Death

November 28 2000

Day

Year

3. Time of Death

9:50 a.m.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

068-30-3198

6. Sex

M 2 F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 27, 1938

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3712 Yolando Road

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

Corrections

17. Father's Name (First, Middle, Last)

Arthur Horne

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Fambro

19a. Informant's Name/Relationship (Type, Print)

Arthur C. Brooks - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7443 S. Rockwell St., Chicago, IL 60629

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cypress Hill Cemetery

Date

12/1/00

20c. Location - City or Town, State

Brooklyn, NY

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CAFA, Stephen D. Lohrmann, P.A.  
8717 Green Pastures Dr., Towson, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

HOSPICE

27. Manner of Death

1 Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

[Signature]

NOVEMBER 28, 2000 9:50 a.m.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

OLIVER HORNE

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38004

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY C. JENKINS</b>				2. Date of Death Month Day Year <b>NOVEMBER 26, 2000</b>		3. Time of Death <b>11:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1023 FAIRWAY AVENUE</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>236-24-5719</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DECEMBER 8, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>WV</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GLEN BURNIE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>1023 FAIRWAY AVENUE</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>OWN HOME</b>			
	17. Father's Name (First, Middle, Last) <b>JEFF EDWARDS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAE PETERS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MR. EDWARD JENKINS (HUSBAND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1023 FAIRWAY AVENUE, GLEN BURNIE, MD. 21061</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRING HILL CEMETERY</b>		20c. Location - City or Town, State <b>HUNTINGTON, WV</b>		20d. Date <b>12/1/00</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Metastatic Breast Cancer</b> Due to (or as a consequence of):  b. <b>Breast Cancer</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
	23b. Approximate Interval Between Onset and Death <b>5 yrs-9 yrs.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>031551</b>		29d. Date signed (Month, Day, Year) <b>November 27, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell R DeLucas, 1600 S Crai Highway, Glen Burnie, Md. 21061</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Baltimore, Maryland 21215-0036  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Katrina D. Jones</b>			2. Date of Death Month <b>NOVEMBER</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>06:30AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>DEATON SPECIALITY HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death			
Funeral Director	5. Social Security Number <b>220-76-2980</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>33</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>04 19 67</b>	9. Birthplace (State or Foreign Country) <b>M.D.</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>231 East Lafayette Ave</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>			
17. Father's Name (First, Middle, Last) <b>Frank Jackson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Jones</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Frank Jackson - Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4400 Manorview Road, Baltimore Md 21229</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>12/1/00</b>		20c. Location - City or Town, State <b>Baltimore, Md</b>			
21. Signature of Funeral Service Licensee <i>Solo March</i>				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MYOCARDIAL FIBROSIS, BRONCHOPNEUMONIA AND MALNUTRITION COMPLICATING END-STAGE SYSTEMIC SCLEROSIS (SCLERODERMA)</b>						Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)								
	Due to (or as a consequence of):								
	Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>J. M. Titus</i>				29c. License number <b>OCME</b>			29d. Date signed (Month, Day, Year) <b>NOVEMBER 28, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <i>[Signature]</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38006

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Samuel John</b>				2. Date of Death Month <b>November</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>1305</b>	
	4a. Facility Name (If not institution, give street and number) <b>Upper Chesapeake Medical Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>215-02-2303</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Jul. 10, 1928</b>	9. Birthplace (State or Foreign Country) <b>Trinidad &amp; Tobago</b>	
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County		10c. City, Town or Location <b>Baltimore City</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1100 Pennsylvania Ave. Apt. 815</b>				10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>Alexander Cornelius John</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ivy Buchan</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mervyn John (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3444 Winter Moss Court, Abingdon, MD 21009</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Location - City or Town, State <b>Dundalk, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 Padonia Road, East, Timonium, MD 21093</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): b. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								1 Hour
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic Prostate Cancer</b> <b>Parkinson's Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>H39022</b>		29d. Date signed (Month, Day, Year) <b>November 28 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PETER LINDESTI, DO, FACD 1305 Business Center Wy Edgewood MD 21040</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature 				

ORIGINAL

2nd 1

Handwritten signature or initials

Handwritten text at the bottom of the page, possibly a date or reference number.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Sharon Jarrett</b>			2. Date of Death Month <b>NOVEMBER</b> Day <b>27</b> Year <b>2000</b>			3. Time of Death <b>9:24 PM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>			4b. City, Town, or Location of Death <b>Towson</b>			4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>213-40-2496</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>September 30, 1941</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1656 Mussula Rd</b>					10f. Zip Code <b>21286</b>			10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto Mechanic</b>			16b. Kind of Business/Industry <b>Auto Repair</b>			
17. Father's Name (First, Middle, Last) <b>Ray Seaman Jarrett</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Loretta Vogelein</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Raymond Jarrett / son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1775 Crater Lake Ave., Medford, Oregon 97501</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Ridge Memorial Park</b>			Date <b>12/1/00</b>		20c. Location - City or Town, State <b>Elkridge, MD</b>			
21. Signature of Funeral Service Licensee <b>Laura C. Hardesty</b>					22. Name and Address of Facility <b>CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>END STAGE LIVER CIRRHOSIS</b> Due to (or as a consequence of): b. <b>ANEMIA - HCT 14%</b> Due to (or as a consequence of): c. <b>MULTIPLE ARTERIAL - VENOUS MALFORMATIONS</b> Due to (or as a consequence of): d. <b>IN CECUM DESCENDING COLON AND RECTUM</b>										Approximate Interval Between Onset and Death <b>YEARS</b> <b>9/2000</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>RIGHT PLEURAL EFFUSION</b>										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Ceballos, MD</b>			29c. License number <b>D 25886</b>		29d. Date signed (Month, Day, Year) <b>Nov. 29-2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LILIA CEBALLOS, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>											
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>			32. Registrar's Signature <b>[Signature]</b>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38008

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Theresa Koth</b>						2. Date of Death Month <b>November</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>4 Am</b>				
	4a. Facility Name (If not institution, give street and number) <b>HCR Manor Care Towson</b>						4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>135-09-5683</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 12, 1911</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>				
	Usual Residence of Decedent												
10a. State <b>Maryland</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Lutherville</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. Street and Number <b>10 Scottsdale Court</b>						10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Clerk</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>			16b. Kind of Business/Industry <b>Social Security Administration</b>					
17. Father's Name (First, Middle, Last) <b>Frank Howarth</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Claire Rhineforth</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Gerard W Koth Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Scottsdale Court Lutherville, Maryland 21093</b>							
20a. Method of Disposition XX <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>			Date <b>11/28/00</b>		20c. Location - City or Town, State <b>Lutherville, Maryland</b>					
21. Signature of Funeral Service Licensee <i>Dennis Stephen Kenak</i>						22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212</b>							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. STROKE (CRANIOTOMY)</b> Due to (or as a consequence of): <b>b. SUBDURAL HEMATOMA</b> Due to (or as a consequence of): <b>c. DEMENTIA</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>d.</b>										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number <b>D24100</b>		29d. Date signed (Month, Day, Year) <b>11-24-2000</b>	
29b. Signature and title of certifier <i>M.L. Prabhakar M.D.</i>										30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M.L. Prabhakar M.D. 300 ARMOY PLACE BAL, MD.</b>			
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>			32. Registrar's Signature <i>Geneva S Sparks</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38009

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Baby Girl Lowther</i>				2. Date of Death Month <i>July</i> Day <i>18</i> Year <i>2000</i>		3. Time of Death <i>8:45</i>	
	4a. Facility Name (If not institution, give street and number) <i>Sonns Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>unknown</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. _____	If Under 1 Year Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) <i>7-18-00</i>	
	9. Birthplace (State or Foreign Country) <i>MD</i>							
Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <i>232 Douglass Court</i>				10f. Zip Code <i>21231</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>N/A</i>		16b. Kind of Business/Industry <i>N/A</i>		
17. Father's Name (First, Middle, Last) <i>Melvin Joseph Williams</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Montina Lowther</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Montina Lowther/mother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>232 Douglass Ct - Bq Hb. Md. 21231</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Dissect</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sonns Hopkins Hospital</i>		Date <i>7/19/00</i>		20c. Location - City or Town, State <i>Bq Hb. Md</i>		
21. Signature of Funeral Service Licensee <i>Deborah Evans</i>				22. Name and Address of Facility <i>SHH- 600 N. Woke St - 21287</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Prematurity - extreme</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death <i>20 wks</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M _____		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>DR Yun Chen Yang</i>				29c. License number <i>Res-000</i>		29d. Date signed (Month, Day, Year) <i>July 18, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Yue-Cheng Yang 600 North Woke Street Baltimore, Maryland 21287</i>								
31. Date filed (Month, Day, Year) <i>NOV 30 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMND ITM#18&amp;

State of Maryland / Department of Health and Mental Hygiene

AMND ITM#17 PER INFMNT. G794 4-4-2001 JAB

Certificate of Death

Reg. No.

00 38010

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRMA YUK YIP LAM

2. Date of Death

November 24, 2000

3. Time of Death

0906

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

074-68-2685

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 6, 1907

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 East Melrose Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

China

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian Chinese

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Residence

17. Father's Name (First, Middle, Last)

Unknown by Informant

LEON LAP JAN

18. Mother's Name (First, Middle, Maiden Surname)

Unknown by Informant

WONG SEE

19a. Informant's Name/Relationship (Type, Print)

Mrs. Isabel Lam Yau (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2857 Pelham Avenue, Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Memorial Park 11/29/2000 Falls Church, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dan Morhaim

29c. License number

D24875

29d. Date signed (Month, Day, Year)

November 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dan Morhaim, MD, 2401 West Belvedere Ave, Baltimore, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

Benjamin S. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38011

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN DARBY LOIZEAUX

2. Date of Death

Month Day Year  
NOVEMBER 28, 2000

3. Time of Death

1:10AM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-12-1998

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Burnbrae Rd.

10f. Zip Code

21204

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

demolition contractor

16b. Kind of Business/Industry

controlled demolition

17. Father's Name (First, Middle, Last)

Alfred Samuel Loizeaux

18. Mother's Name (First, Middle, Maiden Surname)

Edith MacMurchy

19a. Informant's Name/Relationship (Type, Print)

Darby L. Bryant/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

334 Stablers Church Rd. Parkton, MD 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

11/30/00

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

George Fennan

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Rd.  
Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

b. Chronic Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William D. McConnell MD

29c. License number

D42129

29d. Date signed (Month, Day, Year)

11-28-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McConnell, M.D. - 500 West University PKWY STE 1G Baltimore MD 21210

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

Sparks

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

LOIZEAUX, John D





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38012

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PEARL I. LEWIS</b>				2. Date of Death Month <b>November</b> Day <b>23</b> , Year <b>2000</b>		3. Time of Death <b>10:43 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3510 Lyndale Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>579-30-3997</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG 5 1912</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3510 LYNDAL AVENUE</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>CARETAKER</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRIVATE FAMILY</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>BENJAMIN LEWIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSA LEWIS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Michael A. Lewis/Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 7831, BALTIMORE, MARYLAND 21221</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL</b>		20c. Date <b>12-1-00</b>		20d. Location - City or Town, State <b>LAUREL, MARYLAND</b>		
21. Signature of Funeral Service Licensee <i>Charles H. Donnell</i>				22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>At Scene</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>5</b> <b>12</b> <b>2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 24, 2000</b>		
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature <i>James B. Sperry</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-391-0000.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROLYN D. LUCAS				2. Date of Death Month Day Year NOV. 28, 2000				3. Time of Death 9:55pm		
	4a. Facility Name (If not institution, give street and number) STELLA MORRIS AT MERCY				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-96-7884	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 35 Yrs.	8. Date of Birth Month Day Year FEB. 5, 2000	9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 232 S. CLINTON ST.				10f. Zip Code 21224				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. AFRO-AMERICAN Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (14 or 5+) CNA NURSE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CNA NURSE				16b. Kind of Business/Industry NURSING HOME			
17. Father's Name (First, Middle, Last) RAYMOND LUCAS				18. Mother's Name (First, Middle, Maiden Surname) ELMA BOOTH							
19a. Informant's Name/Relationship (Type, Print) ELMA LUCAS (MOTHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 S. CLINTON ST. BALTO, MD. 21224							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date DEC. 4, 2000		20c. Location - City or Town, State balto, MD					
21. Signature of Funeral Service Licensee Bernadine V. Scruggs				22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic cervical cancer Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) hospice									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Du Hong Mo				29c. License number D40854				29d. Date signed (Month, Day, Year) 11/24/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Roseberg MD 301 St Paul Pl Baltimore 21202											
31. Date filed (Month, Day, Year) NOV 29 2000		32. Registrar's Signature Benue B. Apantaku									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38014

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rhoda L. Myers				2. Date of Death Month Day Year November 29 2000		3. Time of Death 11:33 PM	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 98-18-7954	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year 1/24/1924	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 103 Lincoln Avenue				10f. Zip Code 21061		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Clerk		16b. Kind of Business/Industry Value City		
17. Father's Name (First, Middle, Last) J. Garfield Lewis				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Adams				
19a. Informant's Name/Relationship (Type, Print) Art Myers - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Lincoln Avenue, Glen Burnie, MD 21061				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Data 11/30		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Kelly Gregory Fink				22. Name and Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPOTENSIA Due to (or as a consequence of): c. PULMONARY EMBOLISM Due to (or as a consequence of): d. SEVERE ANEMIA								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD						
		29c. License number D45149		29d. Date signed (Month, Day, Year) November 29 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONABAGO B. 301 HOSPITAL DRIVE GLEN BURNIE MD 21061								
31. Date filed (Month, Day, Year) NOV 30 2000		32. Registrar's Signature [Signature]						

ORIGINAL





AMEND#14 PER F.H. G789 11-30-2000 JAB

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JUAN ANGEL MURILLO-MORALES		2. Date of Death Month Day Year NOV. 19, 2000		3. Time of Death 0314 AM	
	4a. Facility Name (If not institution, give street and number) 21ST. AND BARCLAY STREET		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number unknown	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 8 1955
	9. Birthplace (State or Foreign Country) HONDURAS		Usual Residence of Decedent			
To Be Completed by Funeral Director	10a. State N/A	10b. County N/A	10c. City, Town or Location N/A		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number N/A		10f. Zip Code N/A		10g. Citizen of What Country? No	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: HONDURAN	
	14. Race - American Indian, Black, White, etc. Specify: HISPANIC		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown	
	16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) JUAN DE LAS ROSA MURILLO		18. Mother's Name (First, Middle, Maiden Surname) LUISA ANTONIA MORALES	
	19a. Informant's Name/Relationship (Type, Print) Carmen Aponte/Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Maryland Avenue, Baltimore, Maryland 21218			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAMILY PLOT		20c. Location - City or Town, State 12-5-00 JUTICALPA, HONDURAS	
	21. Signature of Funeral Service Location 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVEN., BALTIMORE, MARYLAND 21217			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 11-19-00		28b. Time of Injury 0305 M		
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street.		28f. Location (Street and Number or Rural Route Number, City or Town, State) 21st St and Barclay St		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E		
		29d. Date signed (Month, Day, Year) NOV. 19, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201						
State Registrar	31. Date filed (Month, Day, Year) NOV 30 2000	32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38016

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>BENJAMIN MCCOY</u>				2. Date of Death Month <u>November</u> Day <u>23</u> Year <u>2000</u>		3. Time of Death <u>5:45 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>NORTHWEST HOSPITAL CENTER</u>				4b. City, Town, or Location of Death <u>RANDALLSTOWN</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>245-44-1404</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>66</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>12-20-1933</u>	
	9. Birthplace (State or Foreign Country) <u>S.C.</u>		10a. State <u>MD</u>		10b. County <u>BALTO</u>		10c. City, Town or Location <u>RANDALLSTOWN</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>8611 Pilsen Road</u>		10f. Zip Code <u>21133</u>		10g. Citizen of What Country? <u>U.S.A</u>	
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th grade</u>		College (1-4 or 5+) <u>NA</u>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Construction</u>		16b. Kind of Business/Industry <u>Construction Company</u>	
	17. Father's Name (First, Middle, Last) <u>Elmore McCoy</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Georgiana McCoy</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Ruth McCoy - wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21133</u> <u>8611 Pilsen Road Randallstown, MD</u>			
	20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>King Memorial Park</u>		20c. Location - City or Town, State <u>11/30/00 Randallstown, MD</u>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>Gale March</u>				22. Name and Address of Facility <u>March H. West</u> <u>4300 Wabash Avenue BALTO, MD 21215</u>			
	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Hypoxia</u> Due to (or as a consequence of): <u>b. Aspiration of Food</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>WITH HISTORY OF TWO CARDIOVASCULAR ACCIDENTS</u>						23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown	
	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No						24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)					
	27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide		28a. Date of Injury (Month, Day, Year) <u>NOVEMBER 23</u>		28b. Time of Injury <u>5:35 PM</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury (Home, farm, street, factory, office building, etc.) (Specify) <u>HOME</u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>8611 PILSEN ROAD - RANDALLSTOWN, MARYLAND</u>					
	29e. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, and manner stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <u>Dr. [Signature]</u>				29c. License number <u>D11171</u>		29d. Date signed (Month, Day, Year) <u>NOVEMBER 29, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>405 FREDERICK ROAD, BALTIMORE, MARYLAND 21228</u>							
State Registrar	31. Date filed (Month, Day, Year) <u>NOV 30 2000</u>				32. Registrar's Signature <u>[Signature]</u>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38017

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hazel Bertrus Marks</b>				2. Date of Death Month Day Year <b>NOVEMBER 29, 2000</b>		3. Time of Death <b>12:40AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>232-36-3943</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 13, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Grantsville, W. VA.</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>1220 St. Andrews Way</b>			
	10f. Zip Code <b>21239</b>				10g. Citizen of What Country? <b>United States of America</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>06</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Jessee J. Tuttle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruie Barnes</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Kathlene S. Alberti (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1220 St. Andrews Way Baltimore, Maryland 21239</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>12/02/2000 Mt. Zion, West Virginia</b>		20d. Date	
	21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair, Sr.</b>				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, Md. 21204</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b>						Approximate Interval Between Onset and Death <b>Hours.</b>	
	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Jeffrey L. Gair, Sr.</b>		29c. License number <b>D-12849</b>		29d. Date signed (Month, Day, Year) <b>11-29-00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AH. GHILADI, M.D. 7600 OSLER Dr. Towson Md 21204</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <b>[Signature]</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38018

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHARINE M. PALULIS</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>12:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>216 12 9017</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 9, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3631 Morning View Court</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>		16b. Kind of Business/Industry <b>Insurance</b>					
17. Father's Name (First, Middle, Last) <b>Jacob H. Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna K. Wittmann</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen A. Greer/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3631 Morning View Court Ellicott City, MD 21042</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crest Lawn Mem. Gardens</b>		20c. Location - City or Town, State <b>12-1-2000 Marriottsville, MD</b>					
21. Signature of Funeral Service Licensee <b>Shana Collins</b>		22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of):		b. <b>ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of):		c. <b>RENAL FAILURE</b> Due to (or as a consequence of):		d.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b> <b>CORONARY ARTERY DISEASE</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>K.S. Rao, M.D.</b>		29c. License number <b>043462</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER, 28, 00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K.S. Rao, M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD</b>		31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <b>Benita B. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38019

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert G. Plummer</b>				2. Date of Death Month <b>Nov</b> Day <b>27</b> Year <b>2000</b>				3. Time of Death <b>6:30 PM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Lorien Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>				
Funeral Director	5. Social Security Number <b>212-42-8522</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 21, 1944</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>				
	Usual Residence of Decedent				10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>6425 Danville Ave.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 yrs.</b> College (1-4 or 5+) <b></b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Construction</b>					
17. Father's Name (First, Middle, Last) <b>George C. Plummer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Nodonly</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Peggy Condon sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2309 Lodge Farm Rd. Edgemere Md. 21219</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>				Date <b>Nov. 28 2000</b>		20c. Location - City or Town, State <b>Baltimore</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. <b>Acquired Immune Deficiency - HIV</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>24 YRS</b>					
b. Due to (or as a consequence of):				c. Due to (or as a consequence of):				d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D45757</b>		29d. Date signed (Month, Day, Year) <b>NOV 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MATTHEW McNABNEY 5505 HOPKINS Bayview Circle 21224</b>				31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38020

AMEND#24A&amp;B PER MD. G789 11-30-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Caele Ann Rivers

2. Date of Death

October 4 2000

3. Time of Death

7:06 AM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

42 Oct 4 2000

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1440 Graham Farm Circle

10f. Zip Code

21144

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Infant

15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Infant

15b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

Thomas Michael Rivers

18. Mother's Name (First, Middle, Maiden Surname)

Jacqueline Marie Garvin

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Rivers/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1140 Graham Farm Circle Severna, MD 21144

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

b. Neonatal Asphyxia

Due to (or as a consequence of):

c. Pulmonary hypoplasia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John F. Erwin

29c. License number

D0056211

29d. Date signed (Month, Day, Year)

October 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Erwin MD 3001 South Hanover Street

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FRANCINE L. ROBINSON

Amended item #23a pt I, 27 per MEOG791 1/3/2001 EW

## Certificate of Death

Reg. No.

00 38021

Physician  
/Medical  
Examiner

FRANCINE LOUISE SMITH-ROBINSON

2. Date of Death  
Month Day Year  
NOV. 23, 20003. Time of Death  
1532 PM4e. Facility Name (If not institution, give street and number)  
CARROLL COUNTY GENERAL HOSPITAL4b. City, Town, or Location of Death  
WESTMINSTER4c. County of Death  
CARROLLFuneral  
Director5. Social Security Number  
212-62-92586. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
47 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
Month Day Year  
JULY 12, 19539. Birthplace (State or Foreign  
Country)  
MARYLAND

Usual Residence of Decedent

10a. State  
M.D.

10b. County

10c. City, Town or Location  
BALTIMORE10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

941 WEST LOMBARD STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: BLACK15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

BANK OF AMERICA

17. Father's Name (First, Middle, Last)

FRANKLIN L. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

DORETHEA DAVENPORT

19a. Informant's Name/Relationship (Type, Print)

DORETHEA SMITH MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

813 WINSTON AVE., BALTIMORE, M.D. 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

METRO CREMATORY

Date

12/1

20c. Location - City or Town, State

BALTIMORE, M.D.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HOWELL FUNERAL HOME INC.  
4600 LIBERTY HEIGHTS AVE., BALTO., M.D. 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causes of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?PARTIAL  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

NOV. 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. S. Robinson P. Kaban 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38022

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise Ramaley

2. Date of Death

Month  
11Day  
28Year  
2000

3. Time of Death

4:30 am

4a. Facility Name (If not institution, give street and number)

940 Beaver Bank Circle

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

251-18-7601

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 23, 1922

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

940 Beaver Bank Circle

10f. Zip Code

21286

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James Clyde Daniel, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Boyd

19a. Informant's Name/Relationship (Type, Print)

Bobbie D. Scruggs/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

940 Beaver Bank Cir. Baltimore, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc. 11/29/00 Beltsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Laura C. Hardesty

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Drive Baltimore, MD 21286

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Stroke

Due to (or as a consequence of):

Hypertension

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Ash, M.D.

29c. License number

D53955

29d. Date signed (Month, Day, Year)

11/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bimal Ashor, M.D. 10755 Falls Rd. P.O. Box 360, Lutherville, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

B. Sparks

11/28/00 4:30 AM TOD  
Louise D. Ramaley  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner



Patient known as: Sherman, Labethe L

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 10C PER F.H. G789 11-30-00 WR.

State of Maryland / Department of Health and Mental Hygiene

00 38023

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>La Bethel Lynette Sherman-Conway</b>				2. Date of Death Month <b>November</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>12:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>213-84-1715</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10/12/1964</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>3010 Thorndale Avenue BALTIMORE</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>3010 Thorndale Avenue</b>			10f. Zip Code <b>21215</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>		16b. Kind of Business/Industry <b>Medical Hospital</b>		
17. Father's Name (First, Middle, Last) <b>Raymon Tubman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley West</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Edward Conway/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3010 Thorndale Ave., Baltimore, Maryland 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>12/04/00 Landsdowne, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215</b>				
Physician /Medical Examiner	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypoxic encephalopathy</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b></b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Rolando Falcon M.D.</b>				29c. License number <b>RES 000</b>
29d. Date signed (Month, Day, Year) <b>November 28 2000</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Rolando Falcon 2401 W. Belvedere Baltimore MD 21215</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature 				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM8 PER G789 11-30-00 WR.

## Certificate of Death

Reg. No.

00 38024

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES EDWARD SHERN

2. Date of Death

November 23, 2000

3. Time of Death

12:08 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

216-38-0910

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 12 1943

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

1

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5720 NASCO PLACE

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SUPERVISOR - PURCHASING

16b. Kind of Business/Industry

CITY OF BALTIMORE

17. Father's Name (First, Middle, Last)

CHARLES SHERN

18. Mother's Name (First, Middle, Maiden Surname)

MARQUEZE WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

VIVIAN SHERN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5720 NASCO PLACE BALT. MD. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VET. NOV. 30, 2000 RIEST. MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gary L. Rollins

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME  
110 WEST SOUTH ST. FREDERICK, MD. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Hypertension

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Prabhakar

29c. License number

P 89355

29d. Date signed (Month, Day, Year)

11/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Praya Prabhakar, M.D. 40 Maryland General Hospital

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

Praya Prabhakar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Charles Sheen  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.



MICHAEL

SHAVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38025

AMEND#18 PER INMT. G789 11-30-2000 JAB

Baltimore, Maryland 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MICHAEL LYNN SHAVER</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>8:32P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>233-90-8467</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>May 30, 1953</b>		9. Birthplace (State or Foreign Country) <b>Wes Virginia</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
10e. Street and Number <b>803 Druid Park Lake Drive</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clothing Salesman</b>	
16b. Kind of Business/Industry <b>Retail Clothing</b>		17. Father's Name (First, Middle, Last) <b>Ralph J. Shaver</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Betty L. Shaver Evans</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Betty L. Shaver</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>458 W. Main Street, Grafton, West Virginia 26354</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodsdale Cemetery</b>		20c. Location - City or Town, State <b>12/1/2000 Grafton, West Virginia</b>	
21. Signature of Funeral Service/Licensee <b>Martin D. Lawson</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. <b>Gastrointestinal Hemorrhage</b> Due to (or as a consequence of): b. <b>Chronic Alcoholism</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 27, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38026

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEROME STEWART</b>		2. Date of Death Month Day Year <b>November 26, 2000</b>		3. Time of Death <b>1754 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212-82-3451</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F <b>X</b>	7. Age (In yrs. last birthday) <b>40</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 17, 1960</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	10e. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	10e. Street and Number <b>518 N. DECKER AVENUE</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH</b> Collega (1-4 or 5+) <b>HANDYMAN</b>		16. Kind of Business/Industry <b>SELF EMPLOYED</b>
	17. Father's Name (First, Middle, Last) <b>BUNNICE STEWART</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE BELL-MCDANIELS</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DARLENE WILSON (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>626 N.HIGHLAND AVE. BALTO,MD. 21205</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY DEC.2,2000 BALTO,MD.</b>		20c. Location - City or Town, State
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Bernadine J. Kruger</i>		22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME</b> <b>1412 E. PRESTON STREET BALTO,MD. 21213</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE IN ASSOCIATION WITH END STAGE RENAL DISEASE DUE TO CHRONIC NARCOTISM</b>		Approximate Interval Between Onset and Death		
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		b. Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>J.A. E. M.D.</i>		
	29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 27, 2000</b>		
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, M.D.</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>				
	31. Date filed (Month, Day, Year) <b>NOV 29 2000</b>		32. Registrar's Signature <i>[Signature]</i>		







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38027

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Clinton Thomas JR.</i>				2. Date of Death Month <i>November</i> Day <i>27</i> Year <i>2000</i>				3. Time of Death <i>3:10 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Gilchrest Nursing Home</i>				4b. City, Town, or Location of Death <i>Towson</i>				4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>245-26-9532</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>76</i> Yrs.		8. Date of Birth Month <i>Aug.</i> Day <i>14</i> Year <i>1924</i>		9. Birthplace (State or Foreign Country) <i>N. Carolina</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Catonsville</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>321 Holly Manor Rd.</i>				10f. Zip Code <i>21228</i>				10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+) <i>SKY CAP</i>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>AIRLINE</i>				16b. Kind of Business/Industry	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Clinton Thomas</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Valissa Lawson</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Willie K. Thomas - wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>321 Holly Manor Rd. Catonsville, MD 21228</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Mem. Park</i>		20c. Date <i>12-1-00</i>		20d. Location - City or Town, State <i>Arbutus, MD.</i>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Gary P March Funeral Home, P.A. 270 Fred Hilton Pass Balto., MD 21229</i>					
Physician /Medical Examiner	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>glioblastoma multiforme</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>one year</i>								Approximate Interval Between Onset and Death	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D25205</i>				29d. Date signed (Month, Day, Year) <i>November 27, 2000</i>	
	30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>W. A. Riley 601 N. Charles St. Balto. MD 21204</i>									
31. Date filed (Month, Day, Year) <i>NOV 30 2000</i>				32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38028

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH MARIANNE TRAUGOTT</b>				2. Date of Death Month <b>November</b> Day <b>26</b> , Year <b>2000</b>		3. Time of Death <b>3:45 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Morningside House at Satyr Hill</b>				4b. City, Town, or Location of Death <b>Parkville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-32-9144</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>106</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 3, 1894</b>		9. Birthplace (State or Foreign Country) <b>Germany</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8800 Old Harford Road apt. 304</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>Homemaker</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Georg Karl Theodore Demmer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Johanna Emilie Louisa Siebert</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Stephen Traugott (son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11219 Old Carriage Rd. Glen Arm, Maryland 21057</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Data <b>11-29-00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>George J. Fennan</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>coronary artery disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>hypertension</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>years.</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>assisted living</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Bruce Rosenbergs</b>				29c. License number <b>D24121</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>		
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) <b>BRUCE ROSENBERG 21 WEST RD TOWSON, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature <b>Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38029

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hettie M. Tuck</b>			2. Date of Death Month <b>Nov</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>12:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Eastpoint Nursing Home</b>			4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>226-12-8096</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 18, 1921</b>	9. Birthplace (State or Foreign Country) <b>Va.</b>
	Usual Residence of Decedent						
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>7237 Stratton Way</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9 yrs.</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Grocery Store</b>		
17. Father's Name (First, Middle, Last) <b>Samuel J. Wilson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dortha M. Stevens</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Kyle Tuck Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7237 Stratton Way Dundalk, Md. 21224</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		Date <b>Dec. 1 2000</b>		20c. Location - City or Town, State <b>Dundalk, Md.</b>
21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>			22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk, P.A. 1110 Sollers Point Rd. Dundalk, Md. 21222</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death <b>5 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <b>Matthew McNabney MD</b>		29c. License number <b>D45757</b>		29d. Date signed (Month, Day, Year) <b>Nov 29, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Matthew McNabney 5505 Hopkins Bayview Circle BAC MD 21224</b>							
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>			32. Registrar's Signature <b>James B Sparks</b>				







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38030

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JEANNE VOGEL</u>						2. Date of Death Month <u>November</u> Day <u>22</u> Year <u>2000</u>			3. Time of Death <u>3:50 P.M.</u>			
	4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND HOSPITAL</u>						4b. City, Town, or Location of Death <u>BALTIMORE</u>			4c. County of Death			
Funeral Director	5. Social Security Number <u>219-20-2457</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>72</u> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <u>Nov-30, 1927</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		
	Usual Residence of Decedent												
10a. State <u>MARYLAND</u>		10b. County <u>HARFORD</u>		10c. City, Town or Location <u>WHITEFORD</u>						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <u>2935 WHITEFORD ROAD</u>						10f. Zip Code <u>21160</u>		10g. Citizen of What Country? <u>U.S.A.</u>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 YRS</u> College (1-4 or 5+) <u></u>						18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u>			16b. Kind of Business/Industry <u>AT HOME</u>				
17. Father's Name (First, Middle, Last) <u>EVERS HOLZMAN</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>MARY MOORE</u>							
19a. Informant's Name/Relationship (Type, Print) <u>CLATUS J. VOGEL</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>21160</u> <u>2935 WHITEFORD ROAD WHITEFORD, MARYLAND</u>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>BELAIR MEMORIAL</u>			Date <u>Nov-30, 2000</u>		20c. Location - City or Town, State <u>BELAIR, MARYLAND</u>					
21. Signature of Funeral Service Licensee <u>[Signature]</u>						22. Name and Address of Facility <u>EVANS FUNERAL CHAPEL - BELAIR, P.A. 21000</u> <u>30 NEWPORT DRIVE FOREST HILL, MARYLAND</u>							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Lung Cancer</u> Due to (or as a consequence of):  b. <u></u> Due to (or as a consequence of):  c. <u></u> Due to (or as a consequence of):  d. <u></u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier <u>[Signature] Fernando A. Lopez MD</u>						29c. License number <u>1296</u>			29d. Date signed (Month, Day, Year) <u>November 22, 2000</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. FERNANDO A. LOPEZ 22 SOUTH GREEN STREET BALTIMORE, MD. 21201</u>													
31. Date filed (Month, Day, Year) <u>NOV 30 2000</u>			32. Registrar's Signature <u>[Signature]</u>										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Handwritten text, possibly a signature or name, located in the middle of the page.

Handwritten text, possibly a signature or name, located near the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38031

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie Marian Winand</b>				2. Date of Death Month Day Year <b>Nov. 28 2000</b>		3. Time of Death <b>5:10 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Hamilton Center</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-09-9722</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 16, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>2605 Roselawn Avenue</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>George Huntley</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Pope</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Wallace F. Smith Jr. (Nephew)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2605 Roselawn Avenue Baltimore, Md. 21214</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens Faith Cemetery</b>		20c. Location - City or Town, State <b>12/1/00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Milton J. Knight Jr.</b>		22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214</b>		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arrhythmia</b>		Approximate Interval Between Onset and Death <b>1 Day</b>			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>M</b>		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D45475</b>		29d. Date signed (Month, Day, Year) <b>11-29-00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38032

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Morris Louis Zinkhan				2. Date of Death Month Day Year NOVEMBER 23, 2000		3. Time of Death 8:35 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-18-3563	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 13, 1922		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 222 Spring Ave.				10f. Zip Code 21093		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanic			16b. Kind of Business/Industry automobile	
17. Father's Name (First, Middle, Last) Louis Zinkhan				18. Mother's Name (First, Middle, Maiden Surname) Helena Pieper				
19a. Informant's Name/Relationship (Type, Print) Mary L. Gregory/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 Acorn Rd. Madison, CT 06443				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery		20c. Location - City or Town, State 11/25/00 Towson, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of): RHABDOMYOLYSIS Due to (or as a consequence of): NON-KETOTIC HYPEROSMOLAR SYNDROME								Approximate Interval Between Onset and Death DAYS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LACTIC ACIDOSIS								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D-31826		29d. Date signed (Month, Day, Year) 11-23-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204								
31. Date filed (Month, Day, Year) NOV 30 2000				32. Registrar's Signature 				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020





00 38033

ORIGINAL

1000

NOV 8 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38034

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Ann Brooks				2. Date of Death Month Day Year November 8 2000		3. Time of Death 0050	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center				4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
Funeral Director	5. Social Security Number 215-34-2324		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1934	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 624 Gilbert Road		10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator		16b. Kind of Business/Industry Telephone Company		17. Father's Name (First, Middle, Last) Joseph Farmer Weddle	
	18. Mother's Name (First, Middle, Maiden Surname) Rita Avis Branscome		19a. Informant's Name/Relationship (Type, Print) Anne M. Gredler (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10224 Battlefield Dr., Manassas, VA 20010		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		20c. Date 11/10/00		20d. Location - City or Town, State Bel Air, MD		21. Signature of Funeral Service Licensee Kursken Amy C. Gledler	
	22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STAPHYLOCOCCUS AUREUS SEPSIS		Approximate Interval Between Onset and Death 5 DAYS		Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CLOSTRIDIUM DIFFICILE COLITIS SQUAMOUS CELL CARCINOMA - LIR METASTATIC		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John P. Edwards, MD	
To Be Completed by Physician/Medical Examiner	29c. License number 231775		29d. Date signed (Month, Day, Year) NOVEMBER 8, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN P. EDWARDS, MD 2112 BELAIR ROAD AUSTON, MARYLAND 21047		31. Date filed (Month, Day, Year) NOV 9 2000	
	32. Registrar's Signature B. Sparks		33. State Registrar NOV 9 2000		34. State Registrar NOV 9 2000		35. State Registrar NOV 9 2000	

ORIGINAL

NOV 8 1965

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

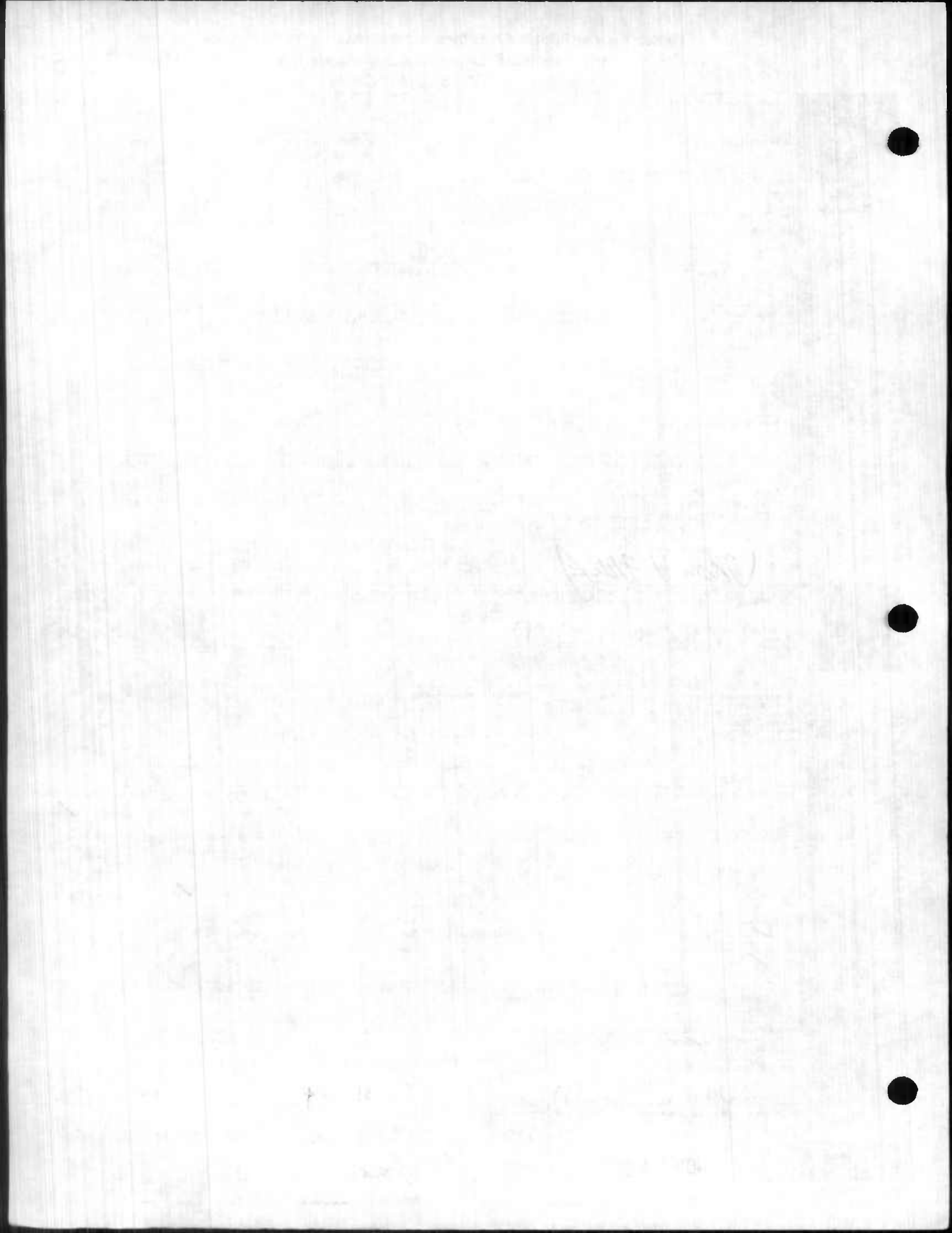
State of Maryland / Department of Health and Mental Hygiene 00 38035

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NANCY S. BEAVER				2. Date of Death Month Day Year NOV. 11, 2000		3. Time of Death 7:30 AM	
	4a. Facility Name (If not institution, give street and number) 523 BLIZZARD LANE				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 220-28-9133	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/7/1934		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County CARROLL	10c. City, Town or Location WESTMINSTER			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 523 BLIZZARD LANE			10f. Zip Code 21157		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER			16b. Kind of Business/Industry MONUMENT CO.		
	17. Father's Name (First, Middle, Last) JOHN E. SAYLOR				18. Mother's Name (First, Middle, Maiden Surname) BELLE EASTON			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) B. MICHAEL STRINE -SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2824 NICODEMUS RD., WESTMINSTER, MD. 21157			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DEER PARK CEMETERY		Date 11/15/00		20c. Location - City or Town, State SMALLWOOD, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D0051924		29d. Date signed (Month, Day, Year) November 13, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminister MD 21157							
31. Date filed (Month, Day, Year) NOV 14 2000		32. Registrar's Signature 						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 17, per F.D.

State of Maryland / Department of Health and Mental Hygiene

11/27/2000, Carroll County, wjl

Certificate of Death

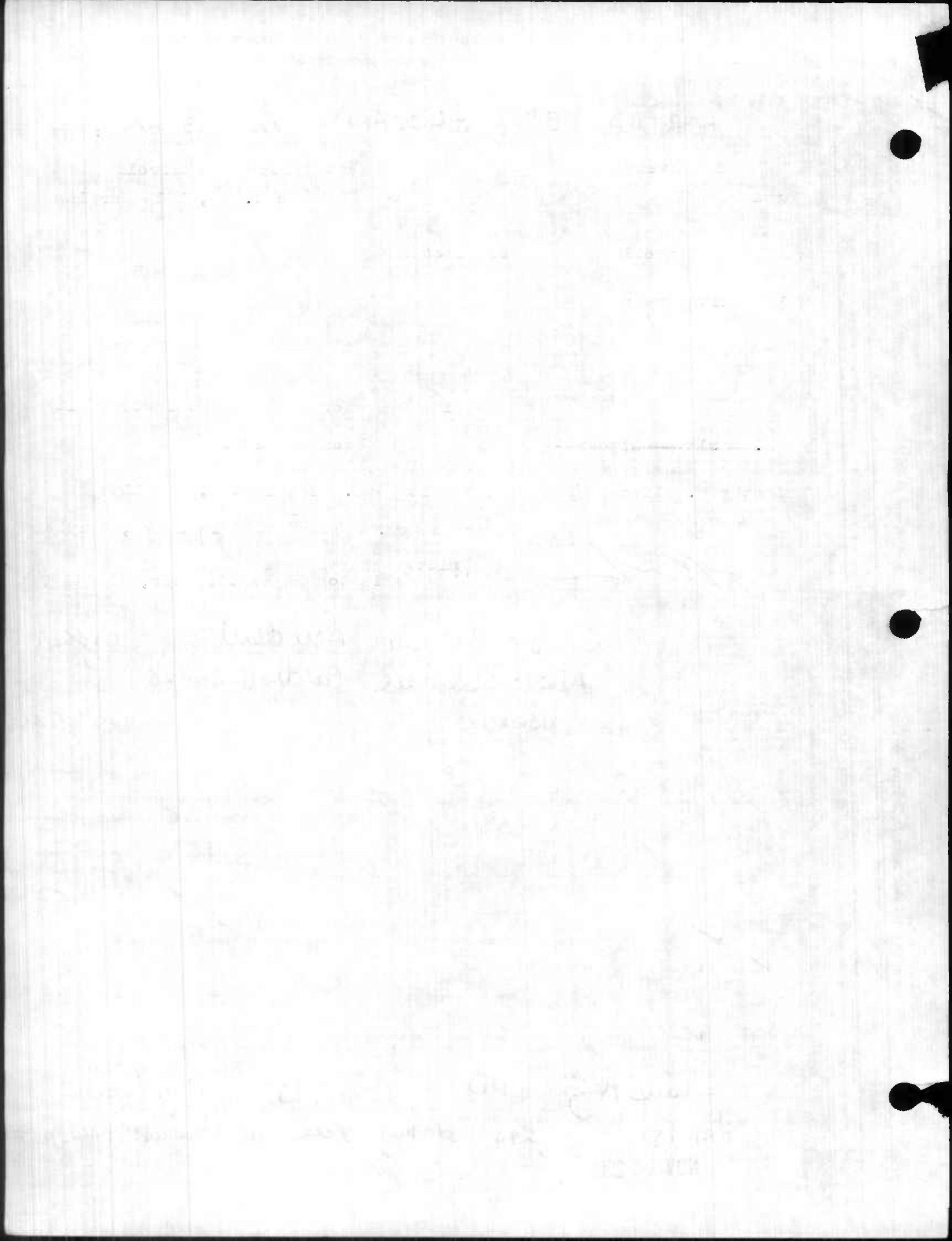
Reg. No.

00 38036

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BERTHA E BLIZZARD</b>		2. Date of Death Month <b>Nov</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>2:25pm</b>
	4e. Facility Name (If not institution, give street and number) <b>157 Smith Avenue</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>213-52-7064</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 20, 1915</b>				
9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>157 Smith Avenue</b>			10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>		16b. Kind of Business/Industry <b>Westminster Knit</b>	
17. Father's Name (First, Middle, Last) <b>Charles Edward Singer</b> <del>B. Harland Blizzard</del>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lucinda Weaver</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Timothy D. Blizzard/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>157 Smith Ave. Westminster, MD 21158</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Garden</b>		20c. Location - City or Town, State <b>11/15 Finksburg, Maryland</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Pritts Funeral Home and Chapel</b> <b>412 Washington Rd Westminster, MD 21157</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebrovascular Accident</b> 1 year					
Due to (or as a consequence of): b. <b>Atherosclerotic Cardiovascular disease</b> 20 years					
Due to (or as a consequence of): c. <b>disease</b>					
Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier MD		29c. License number <b>D38915</b>		29d. Date signed (Month, Day, Year) <b>11/14/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FREISI 295 Stoner Ave Westminster MD 21157</b>					
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38037

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Bower

2. Date of Death  
Month Day Year  
11 - 10 - 003. Time of Death  
1:50 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

LUNGVIEW NURSING HOME

4b. City, Town, or Location of Death

MANCHESTER

4c. County of Death

CARROLL

5. Social Security Number

219-14-9033

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 2, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

612 WASHINGTON Rd

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ARCHITECT

16b. Kind of Business/Industry

LUMBER

17. Father's Name (First, Middle, Last)

WALTER ADAM BOWER

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA MAE ROOP

19a. Informant's Name/Relationship (Type, Print)

E. LOUISE MCCABE/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7611 PARADISE BEACH RD, PASADENA, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLLTON CHURCH CEMETERY 2000

Date

NOV 15

20c. Location - City or Town, State

FINKSBURG, MD

21. Signature of Funeral Service Licensee

Robert A. Nien

22. Name and Address of Facility

WESTMINSTER MD - MYERS FUNERAL HOME 91 WILKES ST 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Steven Shaffer

29c. License number

D33165

29d. Date signed (Month, Day, Year)

11/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Shaffer 2111 Harwood Pike Hanover, MD 21074

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 15 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1907. Dec. 21. 11

1907. Dec. 21. 11

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

*[Faint, illegible handwritten text at the bottom of the page, possibly a signature or date.]*

00-6601-021

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38038

amend Item 23a, 27 per me G791 1/9/01 yf  
DEBORAH  
BAUMGARDNER

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah Jean Baumgardner				2. Date of Death Month Day Year NOVEMBER 20, 2000				3. Time of Death 7:17P.M.		
	4a. Facility Name (If not institution, give street and number) 11802 LIBERTY ROAD				4b. City, Town, or Location of Death FREDERICK				4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 215-52-5032		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 19, 1948		9. Birthplace (State or Foreign Country) Colorado		
	Usual Residence of Decedent										
10e. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 11802 Liberty Rd.				10f. Zip Code 21701				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor of payroll				16b. Kind of Business/Industry county gov't.			
17. Father's Name (First, Middle, Last) Richard Terry				18. Mother's Name (First, Middle, Maiden Surname) Joveta Umphres							
19a. Informant's Name/Relationship (Type, Print) Frank Baumgardner, Jr./husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11802 Liberty Rd. Frederick, MD 21701							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc.				20c. Location - City or Town, State Hampstead, MD			
21. Signature of Funeral Service Licensee Catharine O. Hartzler				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Stephen A. Radentz, M.D.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) NOVEMBER 21, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) NOV 27 2000				32. Registrar's Signature Jenna B Sparks							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

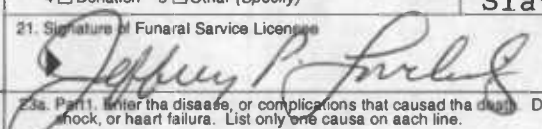
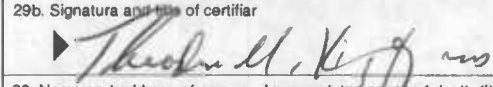

00 38039

JOSHUA MICHAEL BARTHOLD

amend item 23a, 27, 28a, b, c, d, e, f, per me G790 12/14/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSHUA MICHAEL BARTHOLD</b>				2. Date of Death Month Day Year <b>NOV. 21, 2000</b>				3. Time of Death <b>0612 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>936 FRENCHTOWN ROAD</b>				4b. City, Town, or Location of Death <b>PERRYVILLE</b>				4c. County of Death <b>CECIL</b>						
Funeral Director	5. Social Security Number <b>217-08-9183</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>15</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>7/18/1985</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>MD</b>				10b. County <b>Cecil</b>		10c. City, Town or Location <b>936 Frenchtown Road Perryville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>936 Frenchtown Road</b>				10f. Zip Code <b>21903</b>				10g. Citizen of What Country? <b>United States</b>							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Student</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>				16b. Kind of Business/Industry <b>High School</b>							
17. Father's Name (First, Middle, Last) <b>Robert C. Almony</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Laurie D. Ambrose</b>											
19a. Informant's Name/Relationship (Type, Print) <b>Linda R. Barthold</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>936 Frenchtown Road, Perryville, MD 21903</b>											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Slate Ridge Cemetery</b>				Date <b>11/28</b>				20c. Location - City or Town, State <b>Delta, PA</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Harkins Funeral Home, Inc., Delta, PA</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>OXYCODONE INTOXICATION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>found 11/20/00</b>				28b. Time of Injury <b>5:55M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b>				28d. Describe how injury occurred <b>unknown</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>936 Frenchtown Road Perryville, Md</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>				29d. Date signed (Month, Day, Year) <b>NOV. 21, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodore M. Kipp</b>				111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) <b>NOV 27 2000</b>				32. Registrar's Signature 											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38040

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JESSE A BEAVER</b>				2. Date of Death Month <b>November</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>2258</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>202-10-9443</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 24, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>42 Hammond Street</b>		10f. Zip Code <b>21804</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Army</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Specify:</b>				14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Instrument Repair</b>				16b. Kind of Business/Industry <b>Steel</b>		17. Father's Name (First, Middle, Last) <b>Raymond K. Beaver</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie May Fetterman</b>				19a. Informant's Name/Relationship (Type, Print) <b>James R. Beaver/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>917 E. Church St., Salisbury, MD 21804</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Riverside Cemetery</b>		20c. Location - City or Town, State <b>11/13/00 Libertytown, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> Due to (or as a consequence of): <b>Anemia</b> Due to (or as a consequence of): <b>Renal insufficiency</b> Due to (or as a consequence of): <b>Serum</b>				Approximate Interval Between Onset and Death <b>days</b> <b>yes</b> <b>yes</b> <b>yes</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <b>11/13/00</b>				28b. Time of Injury <b>M</b>			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number <b>029349</b>				29d. Date signed (Month, Day, Year) <b>11/13/00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Robins M.D. 1104 Howard Way Dr. Salisbury, MD</b>				31. Date filed (Month, Day, Year) <b>NOV 14 2000</b>			
	32. Registrar's Signature 				33. State Registrar <b>NOV 14 2000</b>			

ORIGINAL

*Handwritten signature*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38041

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STEPHANIE JULIA CHURN</b>				2. Date of Death Month <b>November</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>1930</b>	
	4a. Facility Name (If not institution, give street and number) <b>Upper Chesapeake Medical Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>219-20-5420</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 19, 1916</b>		9. Birthplace (State or Foreign Country) <b>Delaware</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1625 Singer Road</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Zigmond (nmn) Lepkowski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine (nmn) Kukowska</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Frank Churn - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1629 Singer Road, Joppa, Maryland 21085</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Grdns.</b>		Date <b>11/6/00</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Ally McComas Pennington</i>				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or human failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>ACUTE RESPIRATORY FAILURE</b> Due to (or as a consequence of): c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Andrew Nowakowski MD</b>				29c. License number <b>D08096</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014</b>								
31. Date filed (Month, Day, Year) <b>NOV 6 2000</b>		32. Registrar's Signature <i>Benjamin B. Smith</i>						

ORIGINAL







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38042

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sakae Kobayashi Canami</b>					2. Date of Death Month <b>November</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>5:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Forest Hill</b>					4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>181-32-6146</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 28, 1931</b>		9. Birthplace (State or Foreign Country) <b>Japan</b>	
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>348 South Drive</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Oriental</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>In home</b>				
17. Father's Name (First, Middle, Last) <b>Eiji Kobayashi</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Matsue Saito</b>					
19e. Informant's Name/Relationship (Type, Print) <b>Mary Canami (Daughter-in law)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>348 South Drive Aberdeen, Maryland 21001</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc.</b>			Date <b>11/6/00</b>		20c. Location - City or Town, State <b>West Chester, PA</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) a. <u>end stage Parkinson</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <b>D32275</b>			29d. Date signed (Month, Day, Year) <b>November 4, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David S. Dunn 15 W. MacPhail Bel Air, Md.</b>										
31. Date filed (Month, Day, Year) <b>NOV 6 2000</b>			32. Registrar's Signature <i>[Signature]</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

38043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER</b>				2. Date of Death Month <b>November</b> Day <b>3</b> Year <b>2000</b>				3. Time of Death <b>13:28</b>						
	4a. Facility Name (If not Institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>160-14-0530</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 24, 1917</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>						
	Usual Residence of Decedent														
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>7 B Mopec Circle</b>				10f. Zip Code <b>21236</b>				10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) <b>10th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Field Representative</b>				16b. Kind of Business/Industry <b>Union</b>							
17. Father's Name (First, Middle, Last) <b>Frank Ciotola</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sealia DeBell</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Grace E. Ciotola (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7 B Mopec Circle, Baltimore, MD 21236</b>											
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>			Date <b>11/7/00</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>							
21. Signature of Funeral Service Licensee <b>Bruce G. Wieller</b>				22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYELOGENOUS LEUKEMIA</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 months</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SUB-DURAL HEMATOMAS</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>Bruce G. Wieller MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 3, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENJAMIN S. HERMAN, MD 600 NORTH WOLFE STREET, BALTIMORE, MD 21287</b>										31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>		32. Registrar's Signature <b>B. Spade</b>			

0227512

0227512

0227512

0227512

0227512

0227512

0227512

0227512

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38044

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Elizabeth Chalone</u>					2. Date of Death Month <u>NOV</u> Day <u>9th</u> Year <u>00</u>			3. Time of Death <u>140/PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>LORIEN AT RIVERSIDE</u>					4b. City, Town, or Location of Death <u>BELCAMP</u>			4c. County of Death <u>HARFORD</u>	
Funeral Director	5. Social Security Number <u>217-26-8473</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>88</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 7, 1912</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent									
10a. State <u>Maryland</u>		10b. County <u>Harford</u>		10c. City, Town or Location <u>Aberdeen</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <u>1028 North Stepney Road</u>					10f. Zip Code <u>21001</u>			10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u></u>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>			16b. Kind of Business/Industry <u>Own Home</u>		
17. Father's Name (First, Middle, Last) <u>John E. Dolan</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Kate U/K Clark</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Shirley K. Gilbert- Daughter</u>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1028 North Stepney Road, Aberdeen, Maryland 21001</u>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bel Air Memorial Gardens</u>			20c. Location - City or Town, State <u>11/13/00 Bel Air, Maryland</u>				
21. Signature of Funeral Service Licensee <u>Ally McComas Pennington</u>					22. Name and Address of Facility <u>McComas Funeral Home, P.A.</u> <u>1317 Cokesbury Road, Abingdon, Maryland 21009</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Myocardial infarction</u> Due to (or as a consequence of): <u>b. Coronary artery disease</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arterio valve replaced, hypertension,</u> <u>congestive heart failure</u>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred <u></u>	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <u>[Signature]</u>							
29c. License number <u>D27975</u>			29d. Date signed (Month, Day, Year) <u>11/9/00</u>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DAVID SPARKS JR 615 Macphail Rd Bel Air, MD 21014</u>										
31. Date filed (Month, Day, Year) <u>NOV 13 2000</u>			32. Registrar's Signature <u>[Signature]</u>							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

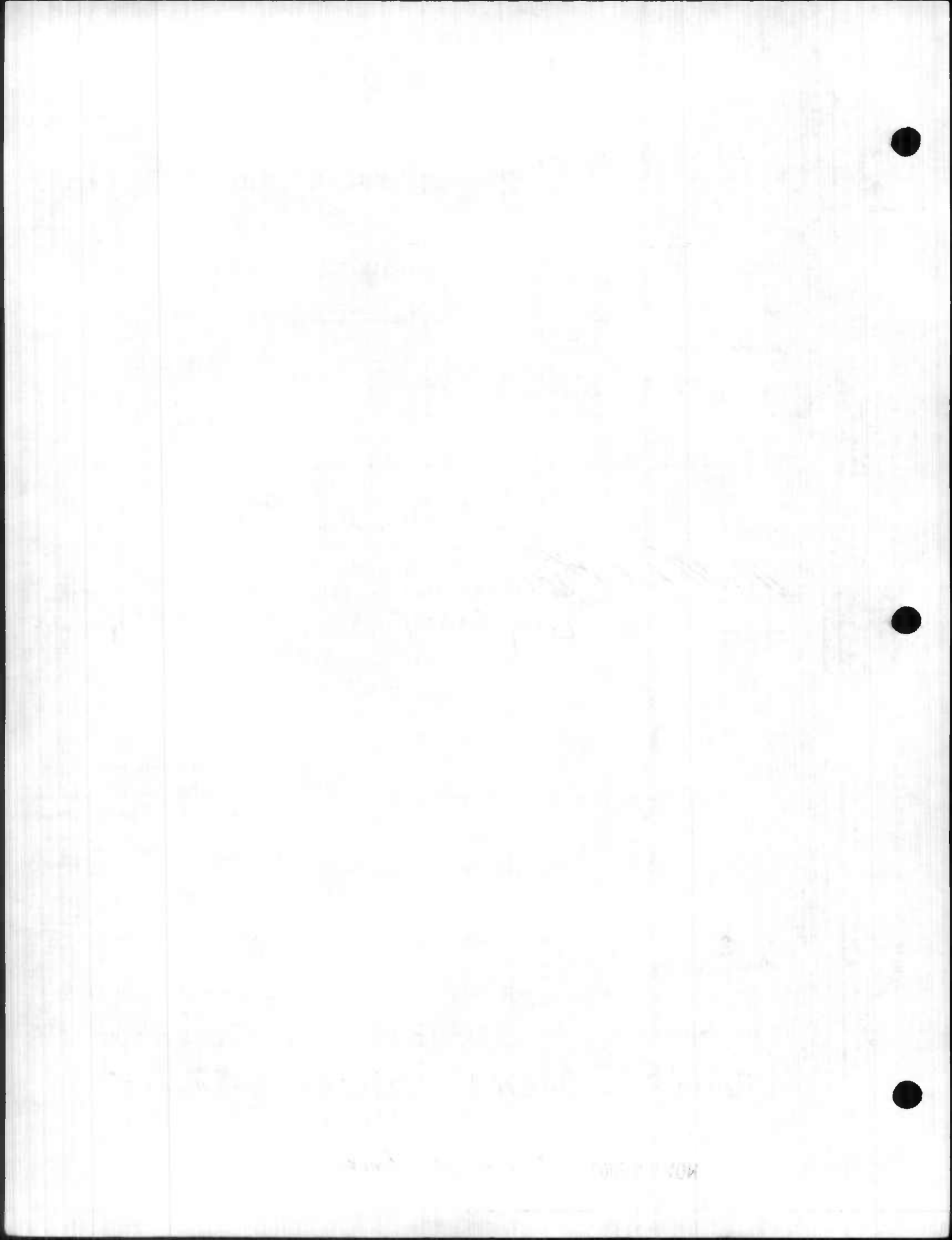
State of Maryland / Department of Health and Mental Hygiene 00 38045

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clarence Edwin CARROLL				2. Date of Death Month Day Year November 20, 2000		3. Time of Death 5:14 p.m.	
	4a. Facility Name (If not institution, give street and number) 8424 Wesley Stinnett Blvd.				4b. City, Town, or Location of Death Chesapeake Beach		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 577 54 2997		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Dec 11, 1940	
	9. Birthplace (State or Foreign Country) Wash., DC		10a. State MD		10b. County Calvert		10c. City, Town or Location Chesapeake Beach	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 8424 Wesley Stinnett Blvd.		10f. Zip Code 20732	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) industrial specialist				16b. Kind of Business/Industry U.S. Gov't.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Clarence Joseph Carroll				18. Mother's Name (First, Middle, Maiden Surname) Thelma Virginia Suggs			
	19a. Informant's Name/Relationship (Type, Print) Deborah Lea Carroll				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Memorial Gardens		20c. Location - City or Town, State 11-25-00 Dunkirk, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						Approximate Interval Between Onset and Death 4 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number 121463		29d. Date signed (Month, Day, Year) 11-22-2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce Silver, M.D. Prince Frederick, MD 20678							
	31. Date filed (Month, Day, Year) NOV 22 2000				32. Registrar's Signature 			

ORIGINAL



00 38046

ORIGINAL



Pamela J. Christian

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38047

amend item 23a, 27, 28a, b, c, d, e, f per me G790 12/1/00 **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAMELA JANE CHRISTIAN</b>				2. Date of Death Month <b>November</b> Day <b>05</b> Year <b>2000</b>		3. Time of Death <b>08:35 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>11905 Bunchberry Lane</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-62-4472</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN 20, 1947</b>		9. Birthplace (State or Foreign Country) <b>OHIO</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GAITHERSBURG</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11905 BUNCHBERRY LANE</b>				10f. Zip Code <b>20878</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>			16b. Kind of Business/Industry <b>OFFICE</b>	
17. Father's Name (First, Middle, Last) <b>FRANCES PRATHER</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>JANE BENNETT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT CHRISTIAN - SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>326 WINDELL AVENUE, ANNAPOLIS, MD 21401</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVERLY CREMATORY</b>			Date <b>11/6/00</b>		20c. Location - City or Town, State <b>FAIRFAX, VIRGINIA</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MEPERIDINE INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11/5/00</b>		28b. Time of Injury <b>unknown</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>11905 Bunchberry Lane, Gaithersburg, MD</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 6, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>NOV 13 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38048

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen DIERING

2. Date of Death

Month

Day

Year

11 07 2000

3. Time of Death

2240

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

220-42-6395

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 29, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

365 Stratford Avenue

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Media Aide

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

George J. Diering, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Eleanora M. Mavers

19a. Informant's Name/Relationship (Type, Print)

Roger W. Strock (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24325 Newbury Rd., Gaithersburg, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

11/11/00 Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kersten A. Unglesbee

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.  
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal failure

Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic papillo-serous adenoma ovaries

Due to (or as a consequence of):

5 years

c. Septic cellulitis-ulceration right ankle

Due to (or as a consequence of):

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Stasis dermatitis legs.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Smith M.D.

29c. License number

D14544

29d. Date signed (Month, Day, Year)

Nov 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN D. SOMERVILLE 400 LEWIS ST. HAVREDEGRACE MD 21078

31. Date filed (Month, Day, Year)

NOV 9 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38049

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE ANNE ECKLOFF

2. Date of Death

November 21, 2000

3. Time of Death

7:40 Am

4a. Facility Name (If not Institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

579-18-3465

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 3, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Charles

10c. City, Town or Location

White Plains

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6975 Bensville Road

10f. Zip Code

20695

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Grabis

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Mary Therres

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Hurst -Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6975 Bensville Road, White Plains, MD 20695

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Memorial Gardens

Date

11-25-00 Waldorf, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home

P. O. Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Failure to thrive

Due to (or as a consequence of):

b. Renal failure

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 month

Few days

Few days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DSuash

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

11.21.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24035 THREE NORTH ROAD HOLLYWOOD MD 20626 A.D. SHAH

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

B. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38050

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn Virginia Eckard				2. Date of Death Month Day Year Nov 13 2000		3. Time of Death 0810	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-12-7783	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 18 1921		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Carroll		10c. City, Town or Location Taneytown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 306 Taney Drive				10f. Zip Code 21787		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Treat Shop	
17. Father's Name (First, Middle, Last) William Crabbs				18. Mother's Name (First, Middle, Maiden Surname) Fern Marie Bowers				
19a. Informant's Name/Relationship (Type, Print) Elizabeth Bowersox/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Ridge Rd Finksburg, MD 21048				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc		20c. Location - City or Town, State 11/13 Hampstead, MD		
21. Signature of Funeral Service Licensed				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Haemorrhagic Stroke Due to (or as a consequence of): b. HTN Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier DR. RAMAN B. KANERIA MD				29c. License number D-0054218		29d. Date signed (Month, Day, Year) 11-13-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. RAMAN B. KANERIA 415-F Malcolm drive Westminster MD 21157								
31. Date filed (Month, Day, Year) NOV 14 2000		32. Registrar's Signature Benita Sparks						







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29c 11/14/2000

State of Maryland / Department of Health and Mental Hygiene

00 38051

per Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SABRINA LYNN ENTREKIN</b>				2. Date of Death Month Day Year <b>NOV 4 2000</b>		3. Time of Death <b>10:50</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIV. OF MARYLAND MEDICAL CTR.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>NONE</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV 4, 2000</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>WESTMINSTER</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>65 CARROLL VIEW AVE</b>				10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>5+</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NONE</b>		16b. Kind of Business/Industry <b>NONE</b>		
17. Father's Name (First, Middle, Last) <b>HARRY RICHARD ENTREKIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>TRACY MAY HARMAN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>FATHER</b> <b>HARRY RICHARD ENTREKIN,</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>65 CARROLL VIEW AVE WESTMINSTER MD. 21157</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOW BRANCH CEMETERY</b>		20c. Location - City or Town, State <b>NOV 7 2000 WESTMINSTER, MD</b>		
21. Signature of Funeral Service Licensee <b>Robert A. Myers</b>				22. Name and Address of Facility <b>MYERS FUNERAL HOME</b> <b>91 WILKES ST. WESTMINSTER MD. 21157</b>				
Physician /Medical Examiner	23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>EXTREME PREMATUREITY</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Robert A. Myers</b>				29c. License number <b>D0054155</b> <b>15155</b>		29d. Date signed (Month, Day, Year) <b>11/4/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CATHERINE MUHAMUZA, UMMS, 22 S. GREENE STREET, BALTIMORE, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>NOV 14 2000</b>				32. Registrar's Signature <b>B Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



00 38052

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38053

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Robert Ford Sr.</i>				2. Date of Death Month <i>Nov.</i> Day <i>11</i> Year <i>2000</i>		3. Time of Death <i>4:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>122 Hawthorne Avenue</i>				4b. City, Town, or Location of Death <i>Pikesville</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>213-10-0641</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>March 27, 1909</i>		9. Birthplace (State or Foreign Country) <i>Massachusetts</i>
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Pikesville</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>122 Hawthorne Avenue</i>				10f. Zip Code <i>21208</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Bus Drive</i>			16b. Kind of Business/Industry <i>Transportation</i>	
17. Father's Name (First, Middle, Last) <i>William Robert Ford</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>India M. Rau</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Mr. Robert T. Ford, Jr. (son)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>122 Hawthorne Ave, Pikesville, MD 21208</i>				
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery</i>		Date <i>11/14/00</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>
21. Signature of Funeral Service Licensee <i>Brian A. Haight</i>				22. Name and Address of Facility <i>HAIGHT FUNERAL HOME &amp; CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>cardiovascular collapse</i> Due to (or as a consequence of):  b. <i>Respiratory failure</i> Due to (or as a consequence of):  c. <i>lung cell carcinoma</i> Due to (or as a consequence of):  d. <i>carcinoma of the bladder</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>2-3 HRS</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Andrew Becker D.O.</i>				29c. License number <i>H 31615</i>		29d. Date signed (Month, Day, Year) <i>11/12/00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>15 Walker Ave Baltimore, MD 21208</i>								
31. Date filed (Month, Day, Year) <i>NOV 15 2000</i>				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I PER HY G789 11-29-00 WR.

Certificate of Death

Reg. No. 00 38054

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lake Erie Fields				2. Date of Death Month Day Year July 24, 2000		3. Time of Death 9:05 a.m.	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 058-28-0291		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 21, 1908	
	9. Birthplace (State or Foreign Country) South Carolina							
Usual Residence of Decedent								
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Coltons Point			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number Rt. 242, Box 6				10f. Zip Code 20626		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician			16b. Kind of Business/Industry Self-employed		
17. Father's Name (First, Middle, Last) Arthur P. Davis				18. Mother's Name (First, Middle, Maiden Surname) Cora Nance				
19a. Informant's Name/Relationship (Type, Print) Linda Kaye Lewis Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7706 East Jefferson Detroit, Michigan 48214 Apartment #101,				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints Episcopal		20c. Location - City or Town, State Avenue, Maryland		
21. Signature of Funeral Service Licensee Mary Rizzo M01114				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  SEPSIS  a. <u>Gangrene Lower Extremity</u> Due to (or as a consequence of): GANGRENE LOWER EXTREMITY  b. <u>Failure to thrive</u> Due to (or as a consequence of): FAILURE TO THRIVE  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death  one month  three months								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of causa of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier SC Gabu M.D.		29c. License number D54346		29d. Date signed (Month, Day, Year) 7/25/00
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Chandra B. Sajja, 24035 Three Notch Road, Hollywood, Maryland 20636								
31. Date filed (Month, Day, Year) JUL 26 2000				32. Registrar's Signature G. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38055

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George A. Gress

2. Date of Death

November 6 2000

3. Time of Death

5:45 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-10-1166

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 16, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4104 Perry View Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

George H. Gress

18. Mother's Name (First, Middle, Maiden Surname)

Margaret A. Carr

19a. Informant's Name/Relationship (Type, Print)

Mrs. Doris E. Gress (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4104 Perry View Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

11/9/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schmunek Funeral Home, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. electromechanical dissociation

30 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. myocardial infarction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michelle Boswell DO

29c. License number

RD198895

29d. Date signed (Month, Day, Year)

11/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Michelle Boswell 9000 Franklin Square Drive Baltimore MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 8 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38056

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Emilie Marie Hunter</i>				2. Date of Death Month <i>November</i> Day <i>6</i> Year <i>2000</i>				3. Time of Death <i>11:40 P.M.</i>		
	4a. Facility Name (If not institution, give street and number) <i>FRANKLIN SQUARE HOSPITAL CENTER</i>				4b. City, Town, or Location of Death <i>ROSEDALE</i>				4c. County of Death <i>BALTIMORE</i>		
Funeral Director	5. Social Security Number <i>215-40-7932</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec. 28, 1919</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent										
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <i>3605 Parkside Drive</i>				10f. Zip Code <i>21214</i>				10g. Citizen of What Country? <i>U. S. A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) <i>8th Grade</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Charles Stach</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Marie Silt</i>							
19a. Informant's Name/Relationship (Type, Print) <i>William R. Hunter (Husband)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3605 Parkside Drive, Baltimore, Maryland 21214</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parkwood</i>		20c. Date <i>11/10/00</i>		20d. Location - City or Town, State <i>Baltimore, Maryland</i>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <i>Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>MULTI-ORGAN FAILURE</i> Due to (or as a consequence of): b. <i>LOW CARDIAC OUTPUT STATE</i> Due to (or as a consequence of): c. <i>HYPOTENSION</i> Due to (or as a consequence of): d. <i>MYOCARDIAL INFARCTION</i>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>NON-INSULIN DEPENDENT DIABETES MELLITUS</i> <i>RECURRENT CONGESTIVE HEART FAILURE</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number <i>D35410</i>		29d. Date signed (Month, Day, Year) <i>November 7, 2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LIYA PFEFFER, MD, 6918 RIDGE ROAD, BALTIMORE, MD 21237</i>											
31. Date filed (Month, Day, Year) <i>NOV 8 2000</i>		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38057

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn Alberta Hurley				2. Date of Death Month Day Year Nov 19 2000		3. Time of Death 1055	
	4a. Facility Name (If not institution, give street and number) Carroll County Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 579 46 3776	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	8. Date of Birth (Month, Day, Year) April 13 1936	9. Birthplace (State or Foreign Country) Washington DC			
	Usual Residence of Decedent							
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 12717 Blair Road				10f. Zip Code 20657		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife/ homemaker		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Albert Arthur Recknor				18. Mother's Name (First, Middle, Maiden Surname) Mary Vaccaro				
19a. Informant's Name/Relationship (Type, Print) Kim Sowers- daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2717 Cove Point Rd. Lusby Maryland 20657				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Middleham Chapel Cemetery		Date Nov 22 2000		20c. Location - City or Town, State Lusby Maryland		
21. Signature of Funeral Service Licensee B Rausch				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Island Road Port Republic MD 20676				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 1/2 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Flavio Kruter MD				29c. License number D35348		29d. Date signed (Month, Day, Year) 11-19-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLAVIO KRUTER 555 S CENTER ST - WESTMINSTER MD 21157								
31. Date filed (Month, Day, Year) NOV 21 2000		32. Registrar's Signature Benjamin S. Sparks						

Handwritten text, possibly a title or subject line.

Handwritten text, possibly a paragraph or list.

Handwritten text, possibly a paragraph or list.

Handwritten text, possibly a paragraph or list.

Handwritten text, possibly a paragraph or list.

Handwritten text, possibly a paragraph or list.

Handwritten text, possibly a paragraph or list.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

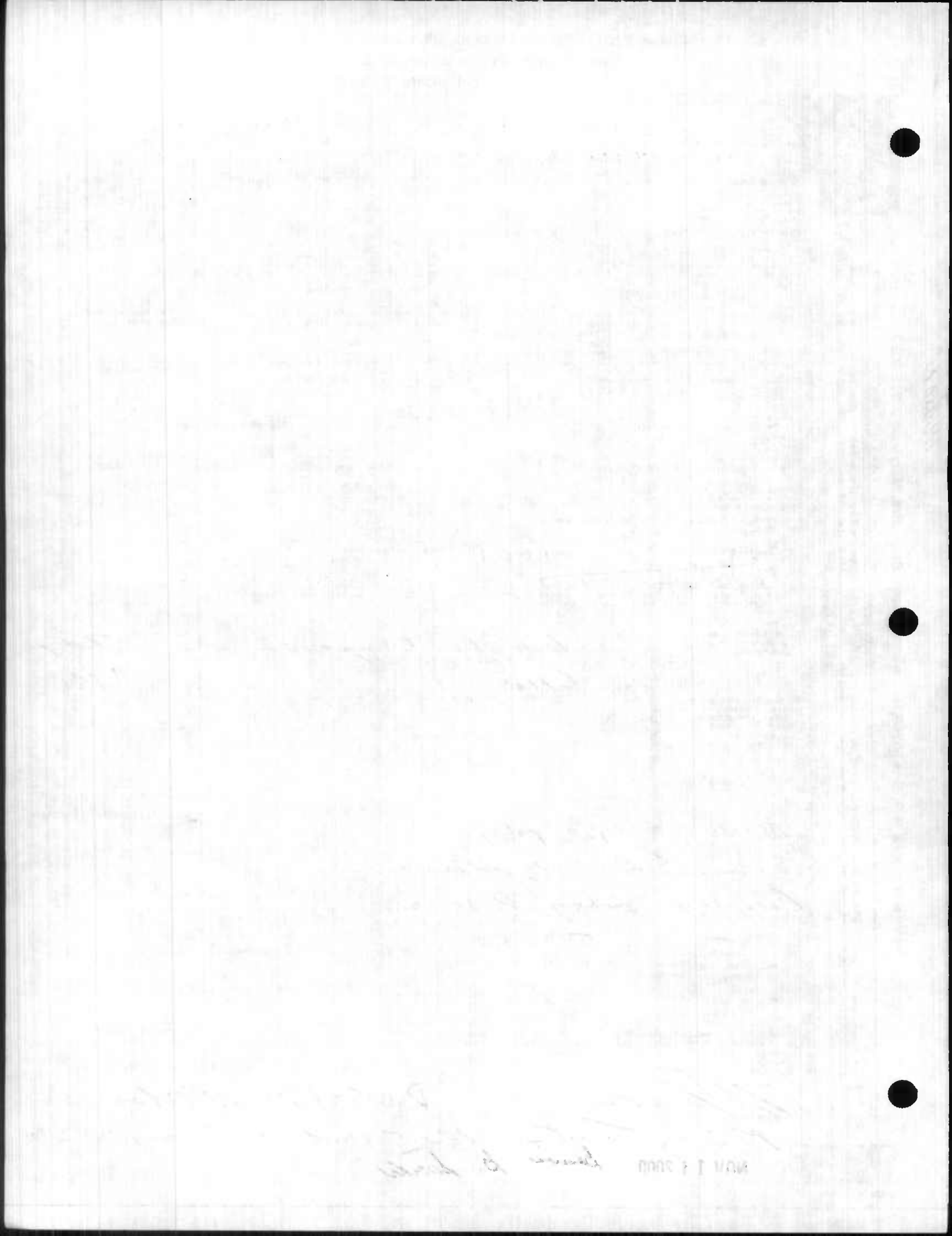
State of Maryland / Department of Health and Mental Hygiene

00 38058

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANN RUTH HUDSON				2. Date of Death Month Day Year November 10, 2000		3. Time of Death 1405
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 217-34-7546	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 22, 1913	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 804D College Lane		10f. Zip Code 21804		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker		16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) John Wiest			18. Mother's Name (First, Middle, Maiden Surname) Leah Light			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Edward C. Hudson Sr./Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804D College Lane, Salisbury, MD 21804			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 11/13/00	20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee <i>David H. Thompson</i> MO1051		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Ventricular Tachycardia</i> Due to (or as a consequence of): b. <i>CHD</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 7 day 1 yr.						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aortic Aneurysm</i> <i>Sick Sinus Syndrome</i> <i>Coronary Artery Disease</i>						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D0054879		29d. Date signed (Month, Day, Year) 11/13/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>106 Maryland St Salisbury MD 21804</i>						
31. Date filed (Month, Day, Year) NOV 14 2000		32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38059

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK BENNETT JAMESON

2. Date of Death

November 18, 2000

3. Time of Death

8:40PM

4a. Facility Name (If not institution, give street and number)

6465 Warren Eller Drive

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

215-48-6063

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth

November 21, 1952

9. Birthplace (State or Foreign

County)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6465 Warren Eller Drive

10f. Zip Code

20646

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
616a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Substance Abuse Counselor Counseling

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Oscar Bennett Jameson, II

18. Mother's Name (First, Middle, Maiden Surname)

Anne Elizabeth Mary Skone

19a. Informant's Name/Relationship (Type, Print)

Yong Jameson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6465 Warren Eller Dr. La Plata, MD 20646

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Brinsfield-Echols Crem. 11/20/00 Charlotte Hall,  
Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Echols

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 2064623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Krishan M. Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

November 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

B. Spence

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38060

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rose Marie Korecky</b>				2. Date of Death Month Day Year <b>November 3 2000</b>				3. Time of Death <b>507 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-26-5522</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Oct. 13, 1930</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5522 McCormick Avenue</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>Specify White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrator</b>		16b. Kind of Business/Industry <b>Marketing</b>				
17. Father's Name (First, Middle, Last) <b>John H. Seidl</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosina Salbeck</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Ronald J. Korecky (husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5522 McCormick Ave., Baltimore, MD 21206</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		Date <b>11/6/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Bea C. Miller</b>				22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Chronic obstructive Pulmonary Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Kevin Brewster D.O.</b>		29c. License number <b>H0055845</b>		29d. Date signed (Month, Day, Year) <b>11/3/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR Kevin Brewster 9000 Franklin Square Drive Baltimore Maryland 21237</b>				31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>		32. Registrar's Signature <b>B. Sparks</b>				

ORIGINAL

Handwritten text, possibly a signature or date, located in the center of the page.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Katherine B. Klein 2. Date of Death Month November Day 6 Year 2000 3. Time of Death 9:51 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Gilchrist Center 4b. City, Town, or Location of Death Towson 4c. County of Death Baltimore

5. Social Security Number 234-30-1601 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 77 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 3, 1923 9. Birthplace (State or Foreign Country) West Virginia

Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 33 Laurel Path Ct. 10f. Zip Code 21236 10g. Citizen of What Country? U.S.A.

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant 16b. Kind of Business/Industry Imports/Exports

17. Father's Name (First, Middle, Last) Janko Micak 18. Mother's Name (First, Middle, Maiden Surname) Barbara Zmegac

19a. Informant's Name/Relationship (Type, Print) Mr. C. John Klein (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Laurel Path Ct., Baltimore, MD 21236

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory Date 11/8/00 20c. Location - City or Town, State Baltimore, Maryland

21. Signature of Funeral Service Licensee Brian C. Miller 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pancreatic cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death 5 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice 27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Anthony Riley, MD 29c. License number D25205 29d. Date signed (Month, Day, Year) November 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GPMC 6701 N. Charles St. Balto. md 2120x

State  
Registrar

31. Data filed (Month, Day, Year) NOV 8 2000 32. Registrar's Signature [Signature]

Klein, Katherine November 6, 2000 9:51pm  
Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

80 38062

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Kraning</u>				2. Date of Death Month <u>11</u> Day <u>5</u> Year <u>2000</u>				3. Time of Death <u>1735</u>	
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical System</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>213-10-7587</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>82</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Dec. 27, 1917</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent									
10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <u>1401 Ramsay Street</u>				10f. Zip Code <u>21223</u>		10g. Citizen of What Country? <u>U.S.A.</u>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th Grade</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Receptionist</u>				16b. Kind of Business/Industry <u>Funeral Service</u>		
17. Father's Name (First, Middle, Last) <u>Thomas A. Starry</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Haddock</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Thomas Kraning (son)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1401 Ramsay Street, Baltimore, MD 21223</u>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>New Cathedral Cemetery</u>		Date <u>11/8/00</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>				
21. Signature of Funeral Service Licensee <u>Christina L. Daniel</u>				22. Name and Address of Facility <u>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) e. <u>Pulmonary embolism</u> Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D0054149</u>		29d. Date signed (Month, Day, Year) <u>11/5/00</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Mario Vespina Univ. of MD Medical Center Baltimore MD 21201</u>										
31. Date filed (Month, Day, Year) <u>NOV 8 2000</u>				32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38063

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Walter Leroy Kammerer</b>				2. Date of Death Month <b>November</b> Day <b>8</b> Year <b>2000</b>				3. Time of Death <b>6:28 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Upper Chesapeake Medical Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>217-16-7454</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 25, 1924</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Edgewood</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1622 B Swallow Crest Drive</b>				10f. Zip Code <b>21040</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1943-45</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Safety Equipment Fabricator</b>		16b. Kind of Business/Industry <b>U.S. Government</b>				
17. Father's Name (First, Middle, Last) <b>Walter Norman Kammerer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cecelia Jeanette Weaver</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy M. Miller / Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1612 A. Swallow Crest Drive, Edgewood, MD 21040</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Memorial Gardens</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>						
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>End-Stage Respiratory Failure</b> weeks</p> <p>b. <b>Chronic Atrial Fibrillation</b> years</p> <p>c. <b>Congestive heart failure</b> years</p> <p>d. <b>Cor pulmonale Pulmonary hypertension</b> years</p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b> <b>Alcohol dependency, Recent skin-graft for large back burn</b>										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D 18779</b>		29d. Date signed (Month, Day, Year) <b>November 8, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1716 Harford Road Ste. 105 Fallston MD 21047</b> <b>ALBERT S.C. SUN, M.D.</b>										
31. Date filed (Month, Day, Year) <b>NOV 9 2000</b>				32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38064

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Horst Otto KLEINSORG				2. Date of Death Month Day Year November 20, 2000		3. Time of Death 220 am		
	4a. Facility Name (If not institution, give street and number) 1072 Cattle Drive Lane				4b. City, Town, or Location of Death Lusby		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 216 60 0922		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) May 30 1934		
	9. Birthplace (State or Foreign Country) Germany		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby		
Usual Residence of Decedent									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
10e. Street and Number 1072 Cattle Drive Lane									
10f. Zip Code 20657									
10g. Citizen of What Country? Germany									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) business owner			
16b. Kind of Business/Industry international import/export			17. Father's Name (First, Middle, Last) Theodor Kleinsorg			18. Mother's Name (First, Middle, Maiden Surname) Emmi Michel			
19a. Informant's Name/Relationship (Type, Print) Ingrid I. Kleinsorg- wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1072 Cattle Drive Lane Lusby MD 20657						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			20c. Location - City or Town, State Alexandria Virginia		20d. Date Nov 20 2000	
21. Signature of Funeral Service Licensee B. Rausch			22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Kidney Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death 5 1/2 years									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder cancer Lung cancer									
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Bruce A. Silver, MD			29c. License number 021463			29d. Date signed (Month, Day, Year) 11-20-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce A. Silver, MD 110 Hospital Rd, Prince Frederick, MD 20678									
31. Date filed (Month, Day, Year) NOV 21 2000			32. Registrar's Signature Benjamin B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38065

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Blanche S. Kaplinsky</b>		2. Date of Death Month Day Year <b>November 23, 2000</b>		3. Time of Death <b>7:18 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Natalie House</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>056-05-4041</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 15, 1906</b>
	9. Birthplace (State or Foreign Country) <b>New York</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>410 Torrington Place</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>Securities &amp; Retail Stock Brokerage</b>
	17. Father's Name (First, Middle, Last) <b>Isaac Saleschetz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Fox</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sarah Crim - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16010 Pennsbury Drive Bowie, Maryland 20716</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Memorial Garden</b>		20c. Location - City or Town, State <b>11/26/00 Falls Church, Va.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. INANITION</b> Due to (or as a consequence of): <b>b. ALZHEIMERS DEMENTIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPOTHYROIDISM</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ASSISTED LIVING</b>
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier 		29c. License number <b>D42403</b>		29d. Date signed (Month, Day, Year) <b>11/23/2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAJ MATHUR IRVING STREET WASHINGTON DC 20010</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature 		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38066

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Gertrude Ladely				2. Date of Death Month Day Year November 5 2000				3. Time of Death 605AM	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-20-7570		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 14, 1925		9. Birthplace (State or Foreign Country) Baltimore	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1002 Downing Court Unit F				10f. Zip Code 21014		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Resource Technician				16b. Kind of Business/Industry U. S. Government			
	17. Father's Name (First, Middle, Last) John Carroll Carr				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Allen					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Max Ladely- Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Downing Court Unit F, Bel Air, Maryland 21014					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 11/09/00		20c. Location - City or Town, State Towson, Maryland			
	21. Signature of Funeral Service Licensee Steph A. Neefs				22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MITRAL VALVE DISEASE AORTIC VALVE DISEASE PERIPHERAL VASCULAR DISEASE									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Dean L. Vasser				29c. License number D0016036		29d. Date signed (Month, Day, Year) NOVEMBER 6, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dean L. Vasser, 104 Plumtree Rd., Bel Air, MD 21015									
State Registrar	31. Date filed (Month, Day, Year) NOV 8 2000				32. Registrar's Signature B. Smith					

NOV 8 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38067

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilda Kathryn Lewis

2. Date of Death  
Month Day Year  
November 7, 20003. Time of Death  
5:30 PM

4a. Facility Name (If not institution, give street and number)

1618 Ashby Square, Apt. A

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

236-14-5597

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 22, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1618 Ashby Square, Apt. A

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clifford (nm) Pritt

18. Mother's Name (First, Middle, Maiden Surname)

Laura O. Bosley

19a. Informant's Name/Relationship (Type, Print)

Beverly K. Duvall / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 Arbor Court, Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Data

11-9-00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Chronic Respiratory Failure

Approximate Interval Between Onset and Death

&gt; 5 years

Due to (or as a consequence of):

b.

Emphysema

&gt; 5 years

Due to (or as a consequence of):

c.

Congestive Heart Failure

5 years

Due to (or as a consequence of):

d.

Atrial Fibrillation

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obstructive, generalized

Esophageal Reflux

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 8 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Coroner (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0016389

29d. Date signed (Month, Day, Year)

November 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALARAO, M.D. 1716 HARTFORD RD SU. 106 FALLSTON MD 20407

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

90 38068

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Thomas Long				2. Date of Death Month Day Year November 19, 2000				3. Time of Death 6:20 p.m.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 579-36-2665		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) 12-04-1929		9. Birthplace (State or Foreign Country) Washington, D.C.	
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Temple Hills	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 5616 Joan Lane				10f. Zip Code 20748	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse				16b. Kind of Business/Industry Nursing Home				17. Father's Name (First, Middle, Last) Cornelius Long	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Mary Helen Lowe				19a. Informant's Name/Relationship (Type, Print) Verna Mae Long/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5616 Joan Lane, Temple Hills, Maryland 20748	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery				20c. Location - City or Town, State Suitland, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. Maryland 20640 4270 Hawthorne Road/P.O. Box 573 Indian Head,				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ACUTE PNEUMONIA Due to (or as a consequence of): b. SQUAMOUS CELL CARCINOMA Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE CORONARY ARTERY DISEASE				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D28281	
	29d. Data signed (Month, Day, Year) NOVEMBER 19, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON BENJERS, 8926 WOODYARD ROAD, CLINTON, MD 20735				31. Date filed (Month, Day, Year) NOV 21 2000	
State Registrar	32. Registrar's Signature 				33. Registrar's Signature 				34. Registrar's Signature 	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38069

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances I. Lukens</b>		2. Date of Death Month <b>Nov</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>9:20pm</b>
	4e. Facility Name (If not institution, give street and number) <b>2905 Old Washington Road</b>		4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>
Funeral Director	5. Social Security Number <b>214-22-7758</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Jan 9 1928</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
10e. Street and Number <b>2905 Old Washington Road</b>				10f. Zip Code <b>21157</b>	
10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		College (1-4 or 5+) <b>College</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>	
17. Kind of Business/Industry <b>English American</b>					
17. Father's Name (First, Middle, Last) <b>John Bailey</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Lenhart</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Edie Garland/daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2905 Old Washington Rd Westminster, MD 21157</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Zion UMC Cemetery</b>		20c. Location - City or Town, State <b>11/14 Westminster, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Pritts Funeral Home and Chapel</b> <b>412 Washington Rd Westminster, MD 21157</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic lung cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None Known</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>715552</b>		29d. Date signed (Month, Day, Year) <b>11/14/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Howard Saintz, M.D. 555 S. Center St. Westminster, Md. 21157</b>					
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 			

Edie Garland\gang.

x

W. K.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38070

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM BRADLEY LEWIS

2. Date of Death  
Month Day Year

11 02 2000

3. Time of Death

1830

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

233-80-9201

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

9/2/1950

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CHESTER

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1139 LITTLE CREEK ROAD

10f. Zip Code

21619

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT MANAGER

16b. Kind of Business/Industry

FOOD INDUSTRY

17. Father's Name (First, Middle, Last)

WILLIAM HOPPER LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

AGNES EATON

19a. Informant's Name/Relationship (Type, Print)

JACQUELINE LEWIS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1139 LITTLE CREEK ROAD CHESTER, MARYLAND 21619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR. 11/8/00 STEVENSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas K. Helfenbein

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
106 SHAMROCK ROAD CHESTER, MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery stent

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospitel:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. J. Sprone

29c. License number

D72136

29d. Date signed (Month, Day, Year)

11/03/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Sprone, MD 2108 N. Donah Ave Chester MD 21619

31. Date filed (Month, Day, Year)

NOV 06 2000

32. Registrar's Signature

G. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38071

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWRENCE</b>		2. Date of Death Month: <b>NOVEMBER</b> Day: <b>4</b> Year: <b>2000</b>		3. Time of Death <b>10:56 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-07-3632</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) <b>March 23, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Baltimore</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>7019 Eastbrook Avenue</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Steel Company</b>
	17. Father's Name (First, Middle, Last) <b>Vincent Metallo</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie C. Natale</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara A. Piechota (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3727 Foxford Stream Road, Baltimore, MD 21236</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>11/8/00 Baltimore, Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b>				Approximate Interval Between Onset and Death <b>5-Days</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number <b>Q7743</b>		29d. Date signed (Month, Day, Year) <b>November 5, 2000</b>
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kerry Dunbar M.D. 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287</b>				
	31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>		32. Registrar's Signature 		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38072

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Violet Hilda MacEwan

2. Date of Death

NOVEMBER 17 2000

3. Time of Death

6:13P.M.

4a. Facility Name (If not institution, give street and number)

15480 Sorrel Ridge

4b. City, Town, or Location of Death

Waldorf,

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

555-01-1408

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 19, 1903

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15480 Sorrel Ridge

10f. Zip Code

20601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Store

17. Father's Name (First, Middle, Last)

Edwin

Jelly

18. Mother's Name (First, Middle, Maiden Surname)

Eliza

Witmore

19a. Informant's Name/Relationship (Type, Print)

Margaret Scaife

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

November 19, 2000  
Metropolitan Funeral Service, Inc. Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home, P.A.

M00668

4270 Hawthorne Road, Indian Head, Md. 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-28352

29d. Date signed (Month, Day, Year)

11/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN M. MATHUR MD 3500 OLD WASHINGTON ROAD WALDORF MARYLAND 20602

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

B. Asante

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #10A-G PER G791 1-11-2000 WR.

## Certificate of Death

Reg. No.

38073

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MORRIS</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>7:28am</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Prince Frederick Calvert</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>312 24 6784</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept 17 1928</b>		9. Birthplace (State or Foreign Country) <b>Indiana</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>ST. MARY'S Lincoln</b>		10c. City, Town or Location <b>New Harbor CALIFORNIA</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>23140 COBBLESTONE LANE #407</b> <b>27 West Strand Road</b>		10f. Zip Code <b>04554 20619</b>		10g. Citizen of What Country? <b>U.S.A.</b> <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Life Insurance Agent</b>		16b. Kind of Business/Industry <b>New York Life</b>	
17. Father's Name (First, Middle, Last) <b>Benjamin Mellinger</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Gongwer</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lara Cogar- daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Bay Ave Prince Frederick Md. 20678</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Nov 17 2000</b> <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>Alexandria Virginia</b>	
21. Signature of Funeral Service Licensee <b>B. Rausch</b>		22. Name and Address of Facility <b>Rausch Funeral Home PA</b> <b>4405 Broomes Is. Rd. Port Republic MD 20676</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Bacterial Endocarditis</b> Due to (or as a consequence of): <b>Bacteremia</b> Due to (or as a consequence of): <b>multi system organ failure</b> Due to (or as a consequence of):					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multi system organ failure</b> <b>Depression</b> <b>Anemia</b>					
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>B. Rausch</b>		29c. License number <b>D0052097</b>		29d. Date signed (Month, Day, Year) <b>11/15/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. JANELLE BELL, MD</b> <b>PRINCE FREDERICK MD 20678</b>					
31. Date filed (Month, Day, Year) <b>NOV 17 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Book 3. 1. 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38074

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Baker Preston

2. Date of Death  
Month Day Year

November 9 2000 9-45 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Western Maryland Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

212-74-0443

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

01/30/1907

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

1500 Pennsylvania Ave.

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Emmett J. Baker

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Sutherland

19a. Informant's Name/Relationship (Type, Print)

Carol B. Wilson- Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

86-10 34th Ave., Apt 511, Jackson Hgts., NY 11372

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

11/11/00 Churchville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Dolaine M. Smith*

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

20 YR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CEREBELLAR DEGENERATION

Due to (or as a consequence of):

20 YR

c. DIABETES MELLITIS

Due to (or as a consequence of):

10 YR

d. SMALL BOWEL OBSTRUCTION

2 MO

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOPHRENIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*M. C. E. S.*

29c. License number

052323

29d. Date signed (Month, Day, Year)

11/9/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Western Maryland Hospital Center 1500 Pennsylvania Ave. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, DE

PRESTON MARGUERITE

2





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38075

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY ANN PHILLIPS		2. Date of Death Month Day Year November 10, 2000		3. Time of Death 6:08 PM
	4a. Facility Name (If not institution, give street and number) 8435 Hilda Drive		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Funeral Director	5. Social Security Number 215-16-3662	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	8. Date of Birth (Month, Day, Year) March 7, 1921	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State: Maryland 10b. County: Wicomico 10c. City, Town or Location: Salisbury 10d. Inside City Limits: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number: 8435 Hilda Drive 10f. Zip Code: 21804 10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4or 5+): -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant 16b. Kind of Business/Industry Utility Co.	
17. Father's Name (First, Middle, Last) Wilmer Covington Ennis		18. Mother's Name (First, Middle, Maiden Surname) Margaret Caroline Campbell			
19a. Informant's Name/Relationship (Type, Print) Gene H. Phillips/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8435 Hilda Dr., Salisbury, MD 21804			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		20c. Location - City or Town, State 11/14/00 Salisbury, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier 		29c. License number D25674 29d. Date signed (Month, Day, Year) 11/13/02	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J A Cockery, MD 100 Down St, Salisbury, MD 21804		31. Date filed (Month, Day, Year) NOV 14 2000 32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John H. Johnson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38076

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace M RICHARDS				2. Date of Death Month Day Year November 19, 2000		3. Time of Death 6:45 a.m.	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213 22 0680		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 18, 1922	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				10a. State MD		10b. County Calvert	
10c. City, Town or Location Prince Frederick				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 6808 Hallowing Lane				10f. Zip Code 20678		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sales clerk		16b. Kind of Business/Industry convenience store		
17. Father's Name (First, Middle, Last) Charles Oliver Lusby				18. Mother's Name (First, Middle, Maiden Surname) Nettie May Ward				
19a. Informant's Name/Relationship (Type, Print) Charles E. Zandarski (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 173, Lusby, MD 20657				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		20c. Location - City or Town, State 11-22-00 Annapolis, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
a. Cerebrovascular accident Due to (or as a consequence of):								1 year
b. arteriosclerosis Due to (or as a consequence of):								10 years
c. gangrene Left Leg. Due to (or as a consequence of):								1 month
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RESPIRATORY INSUFFICIENCY CARDIAC INSUFFICIENCY PERIPHERAL VASCULAR DISEASE						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number D45019		29d. Date signed (Month, Day, Year) 11/21/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN D. MARTIN 104 FORBES ST ANNAPOLIS MD 21401								
31. Date filed (Month, Day, Year) NOV 22 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38077

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Owen RAUSCH						2. Date of Death Month Day Year November 19, 2000		3. Time of Death 6:45 p.m.	
	4a. Facility Name (If not institution, give street and number) 8325 Mt. Harmony Lane						4b. City, Town, or Location of Death Owings		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 220 16 7346		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 12-24-1926		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Calvert		10c. City, Town or Location Owings				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8325 Mt. Harmony Lane				10f. Zip Code 20736		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mortician			16b. Kind of Business/Industry funeral service		
	17. Father's Name (First, Middle, Last) Martin William Rausch, Jr.					18. Mother's Name (First, Middle, Maiden Surname) Mabel Howard				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Myrtle M. Rausch (wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony UM Church Cem.			20c. Location - City or Town, State 11-24-00 Owings, MD			
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Kidney Cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death 3 1/2 years									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Dr. Steven G. Silver, MD					29c. License number D21463		29d. Date signed (Month, Day, Year) 11-20-00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce L. Silver, MD 110 Hospital Rd, Prince Frederick, MD. 20678									
31. Date filed (Month, Day, Year) NOV 22 2000					32. Registrar's Signature Benita S. Sparks					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38078

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Virgil Spalding

2. Date of Death  
Month Day Year  
November 5, 20003. Time of Death  
7:00 AM

4a. Facility Name (If not institution, give street and number)

Rockspring Village

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

216-07-6802

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 9, 1916

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

54 A North Main Street

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner/ Operator

16b. Kind of Business/Industry

Real Estate Sales

17. Father's Name (First, Middle, Last)

Charles Joseph Spalding

18. Mother's Name (First, Middle, Maiden Surname)

Marie Elizabeth Larrison

19a. Informant's Name/Relationship (Type, Print)

Ken Romagna / Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1815 Abelia Road, Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

11-10-00 Bel Air, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles A. Emge

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Renal Cell Carcinoma

Approximate Interval Between Onset and Death

two years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark J. Wild MD

29c. License number

d35522

29d. Date signed (Month, Day, Year)

November 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark J. Wild

2 North Avenue Bel Air, Maryland 21014

31. Date filed (Month, Day, Year)

NOV 8 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38079

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Derek Joel Smith</b>				2. Date of Death <b>November 3, 2000</b>		3. Time of Death <b>2:06 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-90-3769</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>22</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 6, 1978</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> X No		10e. Street and Number <b>2413 Gilwood Drive</b>		10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <b>1</b> X Navar Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> X No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chef</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
	17. Father's Name (First, Middle, Last) <b>Kenneth Smith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Debra Oswald</b>		19a. Informant's Name/Relationship (Type, Print) <b>Alfred Pickard, Sr. (Grandfather)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2413 Gilwood Drive, Joppa, MD 21085</b>	
	20a. Method of Disposition <b>1</b> X Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. Location - City or Town, State <b>11/06/00 Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Benjamin C. Willett</b>		22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Anoxic Brain Injury</b> Due to (or as a consequence of): <b>b. Respiratory Failure</b> Due to (or as a consequence of): <b>c. Cardiac Arrest</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death	
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> X Unknown		24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> X No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> X No			
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> X No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day Year) <b>11/03/00</b>	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> X No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <b>1</b> X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Alan Rhoades MD (PGY-1)</b>		29c. License number <b>P14584</b>		29d. Date signed (Month, Day, Year) <b>11/3/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan Rhoades, M.D. 40 Maryland General Hospital</b>		31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>		32. Registrar's Signature <b>B. Sparks</b>				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38080

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Douglas Sheppard

2. Date of Death

Month Day Year  
November 9, 2000

3. Time of Death

9:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

931 Angel Valley Ct.

4b. City, Town, or Location of Death

Edgewood

4c. County of Death

Harford

5. Social Security Number

217-62-3452

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 4, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

931 Angel Valley Court

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1970-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Ruben John Sheppard

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Marie Alexander

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Sheppard-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

931 Angel Valley Court, Edgewood, Maryland 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith

Date

11/13/00 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 2100923a. Part I. Enter the disease, or complications that caused the death, or Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

D38933

29d. Date signed (Month, Day, Year)

11/10/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert S. Knight, MD 104 Plumtree Rd. Sk 102 Bel Air, MD 21015

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 29c 11/14/2000

State of Maryland / Department of Health and Mental Hygiene

00 38081

Per Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Arthur C. Shipley</i>				2. Date of Death Month <i>November</i> Day <i>9</i> Year <i>2000</i>				3. Time of Death <i>6:15 pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>MD</i>		
Funeral Director	5. Social Security Number <i>212-38-0058</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>60</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Apr 20 1940</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
	Usual Residence of Decedent										
10a. State <i>MD</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Westminster</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <i>1109 Tall Pines Drive</i>				10f. Zip Code <i>21157</i>				10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Tractor Trailer Driver</i>				16b. Kind of Business/Industry <i>SCC Transportation</i>			
17. Father's Name (First, Middle, Last) <i>Arthur Carroll Shipley, Sr.</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Winifred Martin</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Darlene Shipley/wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1109 Tall Pines Dr., Westminster, MD 21157</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadow Branch Cem</i>		20c. Date <i>11/13/00</i>		20d. Location - City or Town, State <i>Westminster, MD</i>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157</i>							
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Aerhythmia</i> Due to (or as a consequence of): b. <i>Smoking</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <i>30 minutes</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>P-14598</i>				29d. Date signed (Month, Day, Year) <i>November 10, 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Annack Rosenberg 22 South Greene St., Baltimore, MD 21201</i>											
31. Date filed (Month, Day, Year) <i>NOV 14 2000</i>		32. Registrar's Signature <i>[Signature]</i>									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 12 per F.D.

State of Maryland / Department of Health and Mental Hygiene 00 38082

11/15/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Edward Shillingburg						2. Date of Death Month Day Year Nov 13 2000		3. Time of Death 1410													
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital						4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll													
Funeral Director	5. Social Security Number 219-14-6252		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Aug 12 1922		9. Birthplace (State or Foreign Country) W VA													
	Usual Residence of Decedent																					
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
10e. Street and Number 525 Mark Drive				10f. Zip Code 21157		10g. Citizen of What Country? USA																
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Baltimore Gas and Electric															
17. Father's Name (First, Middle, Last) Wilbur Shillingburg						18. Mother's Name (First, Middle, Maiden Surname) Hattie Shears																
19a. Informant's Name/Relationship (Type, Print) Eva Shillingburg/wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Mark Drive Westminster, MD 21157																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive Cemetery		Date 11/17		20c. Location - City or Town, State Randallstown, MD														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Ventricular Fibrillation</td> <td>Approximate Interval Between Onset and Death 5 min</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Idiopathic Dilated Cardiomyopathy</td> <td>10 yrs</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	Approximate Interval Between Onset and Death 5 min	b.	Due to (or as a consequence of): Idiopathic Dilated Cardiomyopathy	10 yrs	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Ventricular Fibrillation	Approximate Interval Between Onset and Death 5 min																			
	b.	Due to (or as a consequence of): Idiopathic Dilated Cardiomyopathy	10 yrs																			
	c.	Due to (or as a consequence of):																				
	d.	Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier 				29c. License number D39296		29d. Date signed (Month, Day, Year) 11/14/00																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Ricketts MD CCGH 200 Memorial Ave. Westminister MD 21157																						
31. Date filed (Month, Day, Year) NOV 15 2000				32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38083

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARL FREDERICK SCHOO, JR.						2. Date of Death Month Day Year NOVEMBER 20, 2000		3. Time of Death 7:05A.M.	
	4a. Facility Name (If not institution, give street and number) VAMHCS FORT HOWARD DIVISION						4b. City, Town, or Location of Death FORT HOWARD		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 214-16-7022		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth Month Day Year 8/10/21		9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent									
10a. State VA		10b. County Accomack		10c. City, Town or Location New Church				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6710 Pinewood Lane				10f. Zip Code 23415		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) waterman			16b. Kind of Business/Industry seafood			
17. Father's Name (First, Middle, Last) Earl Frederick Schoo, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Lilly Mae Abell				
19a. Informant's Name/Relationship (Type, Print) Margie M. Schoo (wife)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		Date 11-27-00		20c. Location - City or Town, State Cheltenham, MD		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):										
b. CORONARY ARTERY DISEASE Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Squamous Cell Cancer, Left Side of the Face										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number D57239		29d. Date signed (Month, Day, Year) November 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SURESH SHANDELYA, MD --9600 NORTH Point Road, Ft. Howard, Md 21052										
31. Date filed (Month, Day, Year) NOV 22 2000										
32. Registrar's Signature 										

EARLSCHOO

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1/VA





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38084

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris Rogers Smith</b>				2. Date of Death Month Day Year <b>November 16, 2000</b>				3. Time of Death <b>2:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heartfields Assisted Living At Bowie</b>				4b. City, Town, or Location of Death <b>Bowie</b>				4c. County of Death <b>Prince George's Co.</b>	
Funeral Director	5. Social Security Number <b>353-18-8302</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 1, 1926</b>		9. Birthplace (State or Foreign Country) <b>Indiana</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Calvert Co.</b>		10c. City, Town or Location <b>Dunkirk</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3416 Smithville Drive</b>				10f. Zip Code <b>20754</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Congressional Aide</b>			16b. Kind of Business/Industry <b>Federal Government</b>		
	17. Father's Name (First, Middle, Last) <b>Archie Moody Rogers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eleanor Harvey</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Greg Smith (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3416 Smithville Drive Dunkirk, MD 20754</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem.</b>		Date <b>NOV., 21, 2000</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>METASTATIC ADENOCARCINOMA OF UNCERTAIN PRIMARY</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Approximate Interval Between Onset and Death <b>APPROX. 8 MONTHS</b>									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number <b>D26358</b>		29d. Date signed (Month, Day, Year) <b>November 17, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John H. Weigel, M.D. 110 Hospital Rd. #310, Prince Frederick, MD 20678</b>									
31. Date filed (Month, Day, Year) <b>NOV 17 2000</b>		32. Registrar's Signature 								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38085

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Anna Spence</b>				2. Date of Death Month <b>NOV</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>2000</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>219-07-7488</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 20, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Newark</b>	
Usual Residence of Decedent								
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number <b>6727 Five Mile Branch Road</b>				10f. Zip Code <b>21841</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>housekeeper</b>		16b. Kind of Business/Industry <b>Domestic</b>		
17. Father's Name (First, Middle, Last) <b>Adam Adkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amanda Selby</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mildred Spence/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>27433 Edgewood Circle - Salisbury, MD 21801</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary UM Church Ceme.</b>		20c. Date <b>11/15/00</b>		20d. Location - City or Town, State <b>Berlin, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOLLEY MEMORIAL CHAPEL 21801</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. RENAL FAILURE</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>038353</b>		29d. Date signed (Month, Day, Year) <b>11/15/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RENEE DESMARIS MD 520 AVERAS AVE SALISBURY, MD, 21801</b>								
31. Date filed (Month, Day, Year) <b>NOV 14 2000</b>				32. Registrar's Signature 				

ORIGINAL

*James B. Jones*

NOV 1 8 5010

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38086

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY ELIZABETH REESE SPENCER				2. Date of Death Month Day Year November 9, 2000		3. Time of Death 6:00 AM			
	4e. Facility Name (If not institution, give street and number) 1034 Riverside Drive				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 190-16-4419	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 22, 1916	9. Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent									
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 1034 Riverside Drive				10f. Zip Code 21801		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Elementary Education			
17. Father's Name (First, Middle, Last) Thomas Morrison				18. Mother's Name (First, Middle, Maiden Surname) Ella Hayes						
19a. Informant's Name/Relationship (Type, Print) Marcia R. Puente/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 Quantico Rd., Quantico, MD 21856						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		Date 11/15/00		20c. Location - City or Town, State Arlington, Virginia			
21. Signature of Funeral Service Licensee  m0105i				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804						
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death 2 months.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D 32014		29d. Date signed (Month, Day, Year) 11/13/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH MOONRA 106 WILFORD ST 504 B SALISBURY MD 21804										
31. Date filed (Month, Day, Year) NOV 14 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

38087

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley T. Hart Steward

2. Date of Death

Month Day Year  
Nov. 12, 2000

3. Time of Death

11:02 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

132-12-2116

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-9-1921

9. Birthplace (State or Foreign Country)

N.Y.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

29620 Whipple Dr.

10f. Zip Code

21875

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Albert Tull

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Hotz Tull

19a. Informant's Name/Relationship (Type, Print)

Bruce Hart, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6141 Westbury Dr. Salisbury, Md. 21801

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Springhill Memory Gardens 11-17-2000 Hebron, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Short Funeral Home, Inc.

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metabolic Encephalopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. endometrial cancer

Due to (or as a consequence of):

9 mo.c. Diabetes

Due to (or as a consequence of):

4 mo.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

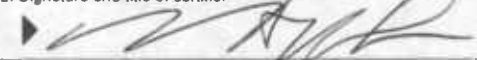
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

027549

29d. Date signed (Month, Day, Year)

11/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, MD

1104 HEALTHWAY DR., SALISBURY, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 14 2000

32. Registrar's Signature

SHIRLEY ALVINA STEWARD  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*Handwritten signature*

NOV 1 1965

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38088

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian Small</b>				2. Date of Death Month <b>November</b> Day <b>25</b> , Year <b>2000</b>		3. Time of Death <b>6:15A.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Ring House</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>212-01-2843</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 18, 1906</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>1801 E. Jefferson Street, #504</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>			16b. Kind of Business/Industry <b>Paint Co.</b>	
17. Father's Name (First, Middle, Last) <b>Akiba Morgenstein</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Reichenthal</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carolyn Shargel - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11021 Haislip Ct. Potomac, Maryland 20854</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>United Hebrew Cemetery</b>		Data <b>11/27/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Myelocytic Leukemia</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D08944</b>		29d. Date signed (Month, Day, Year) <b>November 25, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Martin C. Shargel, M.D. 3720 Farragut Avenue Kensington, Maryland 20895</b>								
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38089

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James A. Tochterman

2. Date of Death

November 5 2000

3. Time of Death

4:20 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-05-4087

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 16, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3901 E. Joppa Road, Apt. T1

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
5th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Brewery

17. Father's Name (First, Middle, Last)

George Tochterman

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Collins

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elizabeth Tochterman (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3901 E. Joppa Rd., Apt. T1, Balt., MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

11/8/00 Baltimore, Maryland

21. Signature of Funeral Service Licensee

B. C. Miller

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hypoxemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. aspiration pneumonia

Due to (or as a consequence of):

3 Days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, coronary artery disease

acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. L. M. D.

29c. License number

D53462

29d. Date signed (Month, Day, Year)

11/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR JUDITH M. SPANOS 9000 Franklin Square Drive Baltimore MD 21237

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 8 2000

32. Registrar's Signature

A. Sparks

Tochterman, James

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Brianna Marie Tighe

amend item 23a, 27, 28a, b, c, d, e, f, per me G790 12/7/00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38090

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brianna Marie Tighe			2. Date of Death Month Day Year November 18 2000		3. Time of Death 06:30 A.M.	
	4a. Facility Name (If not institution, give street and number) 1721 Reisterstown Road Room #207			4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-31-8594	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 2, 1982	9. Birthplace (State or Foreign Country) Md
	Usual Residence of Decedent						
10a. State Md		10b. County Carroll		10c. City, Town or Location Westminster		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1203 Deer Park Road				10f. Zip Code 21157		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student		16b. Kind of Business/Industry none		
17. Father's Name (First, Middle, Last) Sean Michael Tighe				18. Mother's Name (First, Middle, Maiden Surname) Melanie Lynn Carr			
19a. Informant's Name/Relationship (Type, Print) Sean Michael Tighe (father)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1203 Deer Park Rd., Westminster, MD 21157			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 11-22-2000 Sykesville, Md			
21. Signature of Funeral Service Licensee Paige Haight Herbert				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. NARCOTIC INTOXICATION Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): i. Due to (or as a consequence of): j. Due to (or as a consequence of): k. Due to (or as a consequence of): l. Due to (or as a consequence of): m. Due to (or as a consequence of): n. Due to (or as a consequence of): o. Due to (or as a consequence of): p. Due to (or as a consequence of): q. Due to (or as a consequence of): r. Due to (or as a consequence of): s. Due to (or as a consequence of): t. Due to (or as a consequence of): u. Due to (or as a consequence of): v. Due to (or as a consequence of): w. Due to (or as a consequence of): x. Due to (or as a consequence of): y. Due to (or as a consequence of): z. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 11/18/00		28b. Time of Injury found at 6:20		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred unknown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in hotel room		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1721 Reisterstown Road #207 Baltimore, Md			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier David R. Fowler				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) NOV 27 2000		32. Registrar's Signature G. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-333-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38091

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley May Thomas				2. Date of Death Month Day Year Nov. 21, 2000		3. Time of Death 6:00 pm		
	4a. Facility Name (If not institution, give street and number) 14572 Solomons Island Road				4b. City, Town, or Location of Death Solomons		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 579-48-8911		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Mar 6, 1936		
	9. Birthplace (State or Foreign Country) Wash, DC		10a. State MD		10b. County Calvert		10c. City, Town or Location Solomons		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 14572 Solomons Island Road		10f. Zip Code 20688		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Charles Dietrich Uhden				18. Mother's Name (First, Middle, Maiden Surname) Inez Marie Haven					
19a. Informant's Name/Relationship (Type, Print) Charles Thomas/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 11/27/00		20c. Location - City or Town, State Brentwood, MD			
21. Signature of Funeral Service Licensee Raymond Wood				22. Name and Address of Facility Raymond-Wood F.H., P.A. PO Box 430, Dunkirk, MD 20754					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer		Due to (or as a consequence of):		Approximate Interval Between Onset and Death 20 months					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):							
		Due to (or as a consequence of):							
		Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Bruce A. Silver, M.D.		29c. License number D21463		29d. Date signed (Month, Day, Year) 11-22-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce A. Silver, M.D. 110 Hospital Rd, Prince Frederick, MD 20678									
31. Date filed (Month, Day, Year) NOV 2-2 2000		32. Registrar's Signature Benjamin S. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38092

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Jean Camphor Terry				2. Date of Death Month Day Year November 10 2000		3. Time of Death 0747
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 219-46-4062	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 5, 1946	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 715 Meadow Wood Drive			10f. Zip Code 21801		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) consultant		16b. Kind of Business/Industry Verizon		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frank Blake			18. Mother's Name (First, Middle, Maiden Surname) Addie Hayward			
	19a. Informant's Name/Relationship (Type, Print) Frank Terry/husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Meadow Wood Drive - Salisbury, MD 21801			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Acres Mem. Park		Date 11/18/00	20c. Location - City or Town, State Salisbury, Maryland	
	21. Signature of Funeral Service Licensee <i>Patricia D. Jolley</i>		22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 21801 1213 Jersey Road - Salisbury, MD				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>Dr. M.D.</i>			29c. License number D50759		29d. Date signed (Month, Day, Year) 11/10/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES FOLASHADE MD 800 108 PINEBLUFF RD SALISBURY MD						
	31. Date filed (Month, Day, Year) NOV 14 2000			32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL

Handwritten signature or initials.

DDOS 4 1 VGM



Amend Item 16a per F.D., 11/15/2000, Carroll County, wjl  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 1 & 30, per M.E. State of Maryland / Department of Health and Mental Hygiene  
11/15/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 38093

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES GERTRUDE ULCHINSKI</b> <del>FRANCES GERTRUDE ULCHINSKI</del>		2. Date of Death Month <b>NOV</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>14:02 HRS</b>		
	4a. Facility Name (If not institution, give street and number) <b>22 UPPER CHESAPEAKE MED CTZ</b>		4b. City, Town, or Location of Death <b>BEL AIR</b>		4c. County of Death <b>HARFORD</b>		
Funeral Director	5. Social Security Number <b>212-52-4204</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 15, 1910</b>	9. Birthplace (State or Foreign Country) <b>IRELAND</b>
	Usual Residence of Decedent						
10a. State <b>MARYLAND</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>BEL AIR</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2804 FORGE HILL RD.</b>			10f. Zip Code <b>21015</b>		10g. Citizen of What Country? <b>U.S.A</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>College</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b> <del>HOUSEWIFE</del>		16b. Kind of Business/Industry <b>DOMESTIC</b>		
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>RALPH FRIEDLICH / CARE TAKER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>500 RED LAND COURT SUITE 204 OWINGS MILLS, MD 21117</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PIPE CREEK CEMETERY</b>		Date <b>NOV 14 2000</b>		20c. Location - City or Town, State <b>LINWOOD, MD.</b>	
21. Signature of Funeral Service Licensee <b>Robert A. Myers</b>				22. Name and Address of Facility <b>MYERS FUNERAL HOME WESTMINSTER, MD 21157</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ASCD</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Diabetes Mellitus II</b>							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>G. S. Prabhu DME</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>NOV 10 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>G.S. Prabhu G.S. Prabhu, M.D., 728 Bel Air Road, Bel Air, MD 21014</b>							
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature <b>Benjamin S. Sparks</b>					

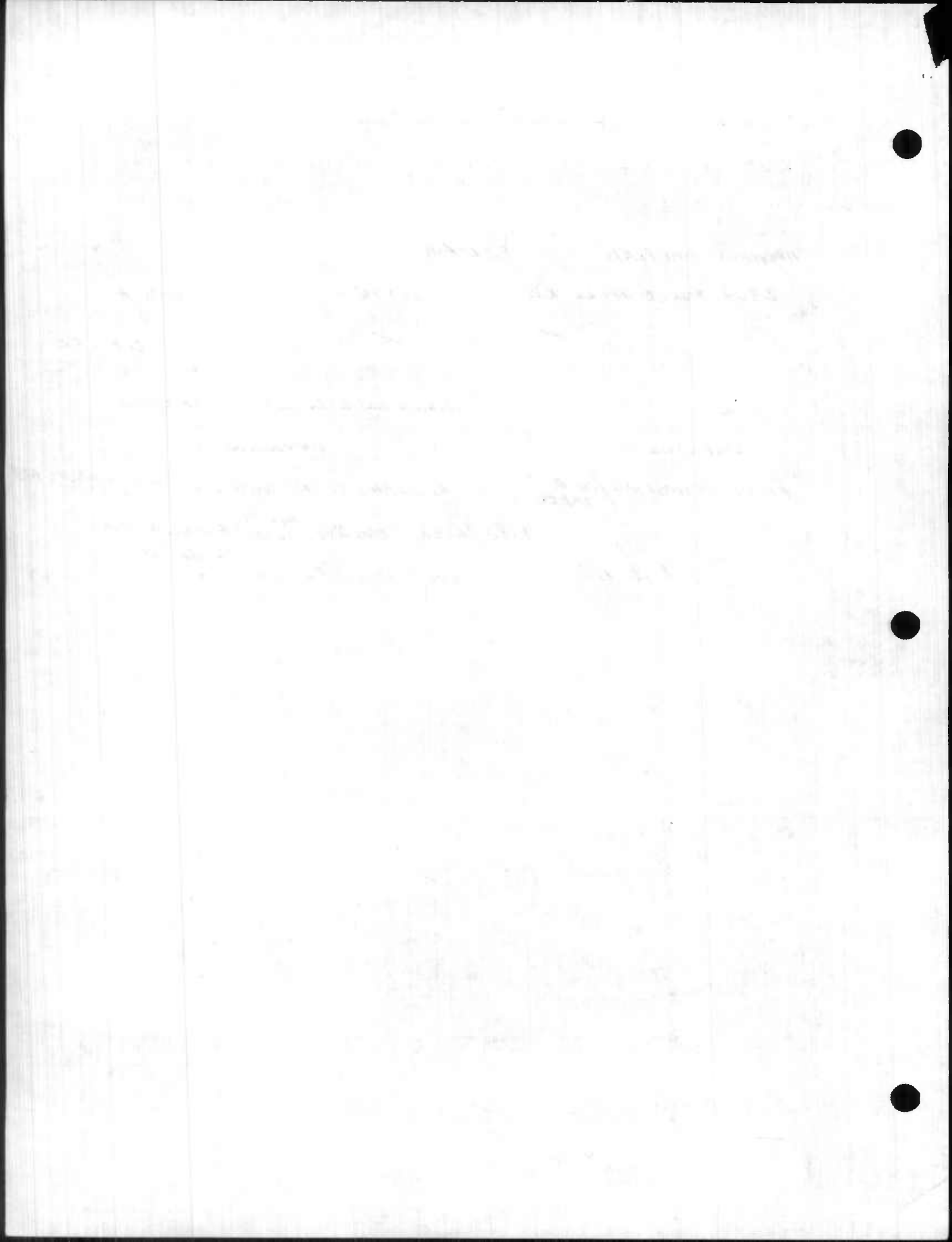
Baltimore, Maryland 21215-0020

per M.E. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38094

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther P. Vickers

2. Date of Death

11 03 2000

3. Time of Death

1205

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

216-56-3309

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/17/1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

md

10b. County

Harford

10c. City, Town or Location

Whiteford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1526 Quarry Road

10f. Zip Code

21160

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Benjamin Jones

18. Mother's Name (First, Middle, Maiden Surname)

Ellen R. Moore

19a. Informant's Name/Relationship (Type, Print)

John H. Vickers-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 Ellis Ave., Delta, PA 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Emory Cemetery

Date

11/07/2000 Street, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins F.H. Inc., 600 Main St. Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Fully Infarcted Bowel

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

{

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

36 Hrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Sepsis

renal Failure

Hepatic Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Ragunap

29c. License number

D 53720

29d. Date signed (Month, Day, Year)

11/03/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

S. Ragunap, 2102 Belair Rd #9, Baltimore, MD 21047

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 6 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

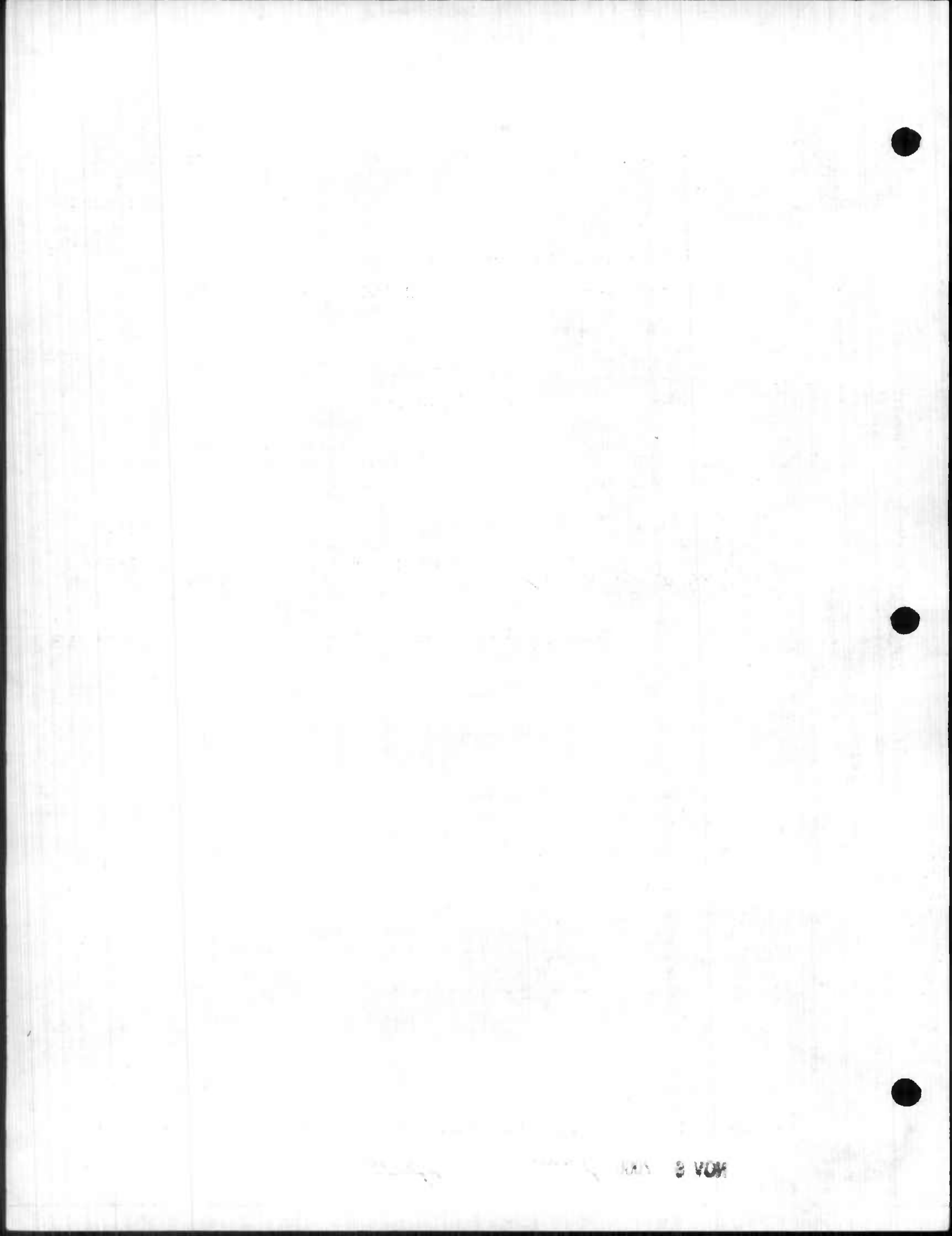
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38095

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie Vontana</b>				2. Date of Death Month <b>November</b> Day <b>5</b> Year <b>2000</b>				3. Time of Death <b>11:10 AM</b>													
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death <b>N/A</b>													
Funeral Director	5. Social Security Number <b>216-52-1142</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 6, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>													
	Usual Residence of Decedent																					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number <b>3717 Foster Avenue</b>				10f. Zip Code <b>21224</b>				10g. Citizen of What Country? <b>U.S.A.</b>														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
15. Decedent's Education (Specify only highest grade completed) <b>6th grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>														
17. Father's Name (First, Middle, Last) <b>Joseph Adamczyk</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Rodamski</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>Lorraine Harrington (Daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>103 Chell Road, Joppatowne, MD 21085</b>																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cem.</b>		20c. Date <b>11/8/00</b>		20d. Location - City or Town, State <b>Dundalk, Maryland</b>														
21. Signature of Funeral Service Licensee <b>[Signature]</b>					22. Name and Address of Facility <b>Schmunek Funeral Home, Inc. 9705 Belair Road, Baltimore, MD 21236</b>																	
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Multisystem Organ Failure</b></td> <td>Approximate Interval Between Onset and Death <b>5 days</b></td> </tr> <tr> <td>b.</td> <td><b>Pseudomonas Pneumonia</b></td> <td><b>1 week</b></td> </tr> <tr> <td>c.</td> <td><b>Aspiration</b></td> <td><b>2 weeks</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<b>Multisystem Organ Failure</b>	Approximate Interval Between Onset and Death <b>5 days</b>	b.	<b>Pseudomonas Pneumonia</b>	<b>1 week</b>	c.	<b>Aspiration</b>	<b>2 weeks</b>	d.		
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Multisystem Organ Failure</b>	Approximate Interval Between Onset and Death <b>5 days</b>																			
	b.	<b>Pseudomonas Pneumonia</b>	<b>1 week</b>																			
	c.	<b>Aspiration</b>	<b>2 weeks</b>																			
	d.																					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																						
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
29b. Signature and title of certifier <b>Albert Michael Ong MD</b>					29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>November 5, 2000</b>															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore MD 21205</b>																						
31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>					32. Registrar's Signature <b>[Signature]</b>																	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Page 10 of 10

10/10/10

10/10/10

10/10/10

10/10/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38096

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Norman Seabury Wells</b>				2. Date of Death Month <b>November</b> Day <b>3</b> Year <b>2000</b>				3. Time of Death <b>11:35 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Manorcare Nursing Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>				4c. County of Death <b>Baltimore County</b>		
Funeral Director	5. Social Security Number <b>217-01-3382</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 19, 1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>9528 Shirewood Court</b>		10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>U.S.A.</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>4th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Worker</b>		16b. Kind of Business/Industry <b>Electric Company</b>							
17. Father's Name (First, Middle, Last) <b>Norman F. Wells</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etta M. Watkins</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Wernsdorfer (step-son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9528 Shirewood Ct., Baltimore, MD 21237</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Date <b>11/07/00</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>					
21. Signature of Funeral Service Licensee <b>Bruce A. Willett</b>				22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Road Baltimore, Maryland 21236</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASPIRATION PNEUMONIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>DAYS</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, TYPE 2</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>11:35 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James Ebeling</b>		29c. License number <b>D34827</b>		29d. Date signed (Month, Day, Year) <b>11/4/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES EBELING, MD 7401 OSLER DR, SUITE 202 TOWSON MD 21204</b>		31. Date filed (Month, Day, Year) <b>NOV 8 2000</b>		32. Registrar's Signature <b>B. Jones</b>							

ORIGINAL

DATE

RECEIVED

RECEIVED

DATE

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38097

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIVIAN LOUISE WYKLE

2. Date of Death

November 6 2000 12:50 pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LORIAN AT RIVERSIDE

4b. City, Town, or Location of Death

BELCAMP

4c. County of Death

HARFORD

5. Social Security Number

213-60-0419

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 8, 1928

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2145 Pulaski Highway

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Emmett Otto Arthur

18. Mother's Name (First, Middle, Maiden Surname)

Thelma (nmn) Kirk

19a. Informant's Name/Relationship (Type, Print)

William D. Wykle - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 Shirley Drive, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

Date

11/10/00

20c. Location - City or Town, State

White Sulphur Springs West Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Carcinoma

1 year

Due to (or as a consequence of):

b. Carcinoma of the Breast

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

D15994

29d. Date signed (Month, Day, Year)

11-7-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LETICIA S. GALVEZ, M.D. 625 S. Union Ave. Havre de Grace Md. 21078

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature

Md. 21078

State  
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

6

Handwritten text at the bottom of the page, possibly a signature or date, followed by the printed text "ASS 8 1 VOM".

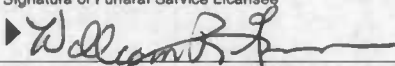

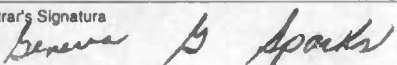
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38098

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JULIANE WOBBEKING</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>21</b> Year <b>2000</b>		3. Time of Death <b>0810am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>579 42 1538</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 6, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Czechoslovakia</b>		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Prince Frederick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>85 Hospital Road</b>		10f. Zip Code <b>20678</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>restaurant hostess</b>		16b. Kind of Business/Industry <b>food service</b>		17. Father's Name (First, Middle, Last) <b>Paul Laszlop</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Bonnie E. Robinson (daug.)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Spruce Lane, Marlton, NJ 08053</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Millers UM Church Cemetery 11-22-00</b>		20c. Location - City or Town, State <b>Manchester, MD</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home, P.A., Owings, MD 20736</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Respiratory failure</b> Due to (or as a consequence of): b. <b>End Stage Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>3 days</b> <b>More than 2 years</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <b>NOV 2 2 2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
	29c. License number <b>D50653</b>		29d. Date signed (Month, Day, Year) <b>11-21-2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>GYAN SURANA, M. D., DEALE, MD 20751</b>		31. Data filed (Month, Day, Year) <b>NOV 2 2 2000</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 		33. State Registrar <b>NOV 2 2 2000</b>		34. State Registrar <b>NOV 2 2 2000</b>		35. State Registrar <b>NOV 2 2 2000</b>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Amend Item#23aptII perPHYG798 8/13/01 EW

AMEND ITEMS: #28A-F PER HY G789 11-21-00 WR.

AMENDED ITEM# 26 per ME G797 071601 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 00 38099

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Francis Walsh

2. Date of Death  
Month Day Year

SEP 23 2000

3. Time of Death

0227

4a. Facility Name (If not institution, give street and number)

Wolfe Cross Hosp

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

207-05-0900

6. Sex

1 ☒ M 2 ☐ F

7. Age (If yrs. last birthday)

83

8. Date of Birth (Month, Day, Year)

Nov 22, 1916

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13221 Holdridge Road

10f. Zip Code

20906-3962

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

U.S. Post Office

17. Father's Name (First, Middle, Last)

John Walsh

18. Mother's Name (First, Middle, Maiden Surname)

Mary Malone

19a. Informant's Name/Relationship (Type, Print)

Gladys P. Walsh/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13221 Holdridge Road, Wheaton, MD 20906-3962

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/25/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Stevenson

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro-vascular accident

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fracture of hip

large cell lymphoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

SEP 7 2000

28b. Time of Injury

7:30 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell at home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

13221 Holdridge Rd Silver Spring, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael A. Dobridge, M.D.

29c. License number

D01138

29d. Date signed (Month, Day, Year)

September 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Dobridge, MD 13975 Connecticut Ave., Silver Spring, MD 20906

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







ROBERTA

State of Maryland / Department of Health and Mental Hygiene

00 38101

ZIMMERMAN

amend item 28c per me G790 12/1/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roberta May Zimmerman			2. Date of Death Month Day Year NOVEMBER 2, 2000			3. Time of Death 4:00P.M.				
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death				
Funeral Director	5. Social Security Number 212-50-0387		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) Jul 13, 1947		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent			10a. State Maryland			10b. County Carroll			10c. City, Town or Location Hampstead	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 3933 Sunset Drive			10f. Zip Code 21074			10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Returns Department Clerk			16b. Kind of Business/Industry London Fog Clothing				
	17. Father's Name (First, Middle, Last) Emory Oursler			18. Mother's Name (First, Middle, Maiden Surname) Helen Lawson							
	19a. Informant's Name/Relationship (Type, Print) Richard Zimmerman Sr, husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3933 Sunset Dr, Hampstead, MD 21074							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hampstead Cemetery			Date 11/6/2000			20c. Location - City or Town, State Hampstead, MD	
	21. Signature of Funeral Service Licensee M00723 Eline			22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			e. Multiple injuries Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of):			c. Due to (or as a consequence of):			d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) 11/2/00		
28b. Time of Injury 1:40 PM			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28d. Describe how injury occurred Subject driven struck another vehicle			28e. Location (Street and Number or Rural Route Number, City or Town, State) Hampstead Pike + 96th Elk Road Baltimore County Maryland		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Theodore M. King			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) NOVEMBER 3, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M. KING			31. Date filed (Month, Day, Year) NOV 06 2000			32. Registrar's Signature penner B Sparks			111 Penn Street, Baltimore, Maryland 21201		
State Registrar											

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38102

amend item 23a, per me G790 12/1/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wanda Eleanor Anoweck				2. Date of Death Month Day Year November 25, 2000		3. Time of Death 5:47 PM	
	4a. Facility Name (If not institution, give street and number) 2503 Gray Manor Terrace				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-16-9799		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 23, 1923	
	9. Birthplace (State or Foreign Country) Pennsylvania							
Usual Residence of Decedent								
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2507 Gray Manor Terrace				10f. Zip Code 21222		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years College (1-4 or 5+) Coлега (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson			16b. Kind of Business/Industry Retail Sales	
17. Father's Name (First, Middle, Last) Thomas Zarembo				18. Mother's Name (First, Middle, Maiden Surname) Louise Pelczar				
19a. Informant's Name/Relationship (Type, Print) Marlene Fackett (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Gray Manor Terrace Dundalk, Maryland 21222				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 11/29/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ARRHYTHMIA</u> <u>Sudden Cardiac Death</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Seconds <u>Seconds</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Viral Illness</u> <u>Hypertension</u> <u>Multi Infarct Dementia</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Residence</u>						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier MD				29c. License number 00056056		29d. Date signed (Month, Day, Year) 11/27/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwen Oldenquist MD Elder House Call 5505 Hopkins Bayview Circle; Baltimore, MD 21224								
31. Date filed (Month, Day, Year) DEC - 1 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 30 PER D.V.R. G790 12-1-00 WR. State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38103

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lenor A. Atkins

2. Date of Death

Nov.

Day 24, Year 2000

3. Time of Death

6:05A.M.

4a. Facility Name (If not Institution, give street and number)

Ridgeway Manor Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-66-4449

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

December 18, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5743 Edmondson Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Marshall E. Hart

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Depeu

19e. Informant's Name/Relationship (Type, Print)

Louise R. Gatzia-Sister-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Coventry Way, Noblesville, Indiana 46060

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

11-27-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Jepperson

22. Name and Address of Facility

Loudon Park Funeral Home  
3620 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hypertensive Atherosclerotic Coronary Vascular Disease, year.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

Cognitive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael H. Schwartz

29c. License number

D18667

29d. Date signed (Month, Day, Year)

11-26-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL H. SCHWARTZ

5517 A-RITCHIE HIGHWAY

BALTIMORE MD

21225

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-8.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38104

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Delma Wilson Aylor</i>				2. Date of Death Month <i>November</i> Day <i>29</i> Year <i>2000</i>		3. Time of Death <i>0535 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Baltimore Veterans Administration Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore, MD</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>215-24-4915</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>72</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Aug. 24, 1928</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Dundalk</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>1913 Inverton Road</i>				10f. Zip Code <i>21222</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 Years</i> College (1-4 or 5+) <i>Clerk</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Clerk</i>		16b. Kind of Business/Industry <i>Steel Industry</i>		
17. Father's Name (First, Middle, Last) <i>Delma W. Aylor, Sr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Inez Darling</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Lois G. Aylor (Wife)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1913 Inverton Road Dundalk, Maryland 21222</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Holly Hill Mem. Gdns. 12/2/2000</i>		20c. Location - City or Town, State <i>Middle River, MD</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Pneumonia</i> Due to (or as a consequence of):  <i>Diabetes</i> Due to (or as a consequence of):  <i>Stroke</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Diabetes</i> <i>Stroke</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature] MD</i>		29c. License number <i>413115</i>		29d. Date signed (Month, Day, Year) <i>November 29, 2000</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Lance Uradomo, MD 10 N. Greene St. Baltimore MD 21201</i>								
31. Date filed (Month, Day, Year) <i>DEC - 1 2000</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38105

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

E/Elizabeth Brown

2. Date of Death

Month

Day

Year

November 25, 2000

3. Time of Death

7:48 pm

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-40-1451

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

05 10 13

9. Birthplace (State or Foreign Country)

V.A.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2119 Gay Brook Road

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5th grade

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Hank W. Lee

18. Mother's Name (First, Middle, Maiden Surname)

Roberta

19a. Informant's Name/Relationship (Type, Print)

Doranna Askins-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2119 Gay Brook Road, Baltimore Md 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National

Date

12/1/00 Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sup 515  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State  
Registrar

DEC 1 2000

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38106

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH THOMAS BRESCH</b>				2. Date of Death Month <b>November</b> Day <b>06</b> Year <b>2000</b>		3. Time of Death <b>6:48 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Harbor Hospital Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>unk</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Nov 26, 1951</b>	9. Birthplace (State or Foreign Country) <b>unk</b>		
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Federalsburg</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3676 Houston Branch Road</b>				10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>			
17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>					
19a. Informant's Name/Relationship (Type, Print) <b>O.C.M.E.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Penn Street Baltimore, MD 21201</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Narcotic Intoxication</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 11-06-2000</b>		28b. Time of Injury <b>Found: 6:20 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred <b>Unknown</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>925 Jack Street Baltimore, Maryland</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 07, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John E. Smialek, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>				32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38107

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY S. BROWN

2. Date of Death

NOVEMBER 17, 2000

3. Time of Death

11:38 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2637 Purnell Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

214-14-8228

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 28, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2637 Purnell Drive

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Walter Scarburgh

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Rogerson

19a. Informant's Name/Relationship (Type, Print)

Robert Scarburgh/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8546 Mary Betts Way Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction  
Due to (or as a consequence of):

immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease  
Due to (or as a consequence of):

months

c. Adult onset Diabetes Mellitus  
Due to (or as a consequence of):

yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-34868

29d. Date signed (Month, Day, Year)

Nov 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Dwyer 11055 Little Potomac Rd Columbia, MD 21044

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38108

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sister Mary Margaretta Bell, OSP

2. Date of Death  
Month Day Year  
11-29-003. Time of Death  
9:30p.m.

4a. Facility Name (If not institution, give street and number)

Oblate Sisters of Providence (HCU)

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-54-5088

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-12-14

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore (Catonsville)

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

701 Gun Road

10f. Zip Code

21227-3899

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: African-American

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

MA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

William A. Bell

18. Mother's Name (First, Middle, Maiden Surname)

Marie Capps

19a. Informant's Name/Relationship (Type, Print)

Sister M. Alexis Fisher, OSP

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

701 Gun Road Baltimore, MD 21227-3899

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/5/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Blynn B. Harris

22. Name and Address of Facility

MARCH FUNERAL HOME WEST, INC.  
4300 WABASH AVE. BALTO., MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Arterio Sclerotic Cardio Vascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Baskaran MD

29c. License number

D 21649

29d. Date signed (Month, Day, Year)

Nov 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM BASKARAN, 3455 Wilkens Ave, Baltimore, MD 21229

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

PHYLLIS

State of Maryland / Department of Health and Mental Hygiene 00 38109

BROWN amend item 23a,ptII,27 per me G790 12/19/00 yf Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHYLLIS BROWN						2. Date of Death Month Day Year NOVEMBER 10, 2000		3. Time of Death 9:13P.M.	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL						4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number unk		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Feb 12, 1957		9. Birthplace (State or Foreign Country) unk	
	Usual Residence of Decedent									
10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1404 W. Pratt Street				10f. Zip Code 21223		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk			16b. Kind of Business/Industry unk			
17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk						
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) Data			20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ACQUIRED IMMUNODEFICIENCY SYNDROME Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NARCOTISM, HEPATITIS C, SICKLE CELL ANEMIA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Stephen S. Radentz, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 11, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature B. Sparks								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38110

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Virgil Brooks</i>						2. Date of Death Month <i>November</i> Day <i>21</i> Year <i>2000</i>			3. Time of Death <i>8:50 p.m.</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center Baltimore</i>						4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death		
Funeral Director	5. Social Security Number <i>219-38-2886</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>58</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <i>July 17, 1942</i>	
	9. Birthplace (State or Foreign Country) <i>unk</i>											
Usual Residence of Decedent												
10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>11 S. Charles Street</i>						10f. Zip Code <i>21230</i>			10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>unk</i> If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>unk</i> College (1-4 or 5+) <i>unk</i>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>maintenance man</i>			16b. Kind of Business/Industry <i>state hwy adm</i>			
17. Father's Name (First, Middle, Last) <i>unk</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>unk</i>						
19a. Informant's Name/Relationship (Type, Print) <i>UMMS</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>22 Greene Street Baltimore, MD 21201</i>						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>						20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>						22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Sepsis</i> Due to (or as a consequence of): <i>b. Pneumonia</i> Due to (or as a consequence of): <i>c. Rectal Adeno Carcinoma</i> Due to (or as a consequence of): <i>d.</i>										Approximate Interval Between Onset and Death <i>4 days</i> <i>5 days</i>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>M.D. resident physician</i>						29c. License number <i># P13418</i>			29d. Date signed (Month, Day, Year) <i>November 21, 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Sarah Werbel, M.D. 22 South Green St. Baltimore MD 21230</i>												
31. Date filed (Month, Day, Year) <i>DEC 1 2000</i>						32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 0006.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

00 38111

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <i>Minnie Bell</i>					2. Date of Death Month <i>11</i> Day <i>29</i> Year <i>2000</i>		3. Time of Death <i>4:25 A</i>	
	4a. Facility Name (If not institution, give street and number) <i>Future Care Old Court</i>					4b. City, Town, or Location of Death <i>Randallstown, Md.</i>		4c. County of Death <i>Baltimore</i>	
<b>Funeral Director</b>	5. Social Security Number <i>213.28.1719</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>102</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 14, 1898</i>		9. Birthplace (State or Foreign Country) <i>Virginia</i>	
	Usual Residence of Decedent								
10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Randallstown</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>5412 Old Court Road</i>				10f. Zip Code <i>21133</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>			
17. Father's Name (First, Middle, Last) <i>Thomas Claiborne</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Lelia Pettus</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Adele Fing/ Niece</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3006 Essex Road Baltimore, MD 21207</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadowridge Mem. Park</i>		20c. Location - City or Town, State <i>11/30 Elkridge, MD</i>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <i>Gary L. Kaufman Funeral Home at Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, MD 21075</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>PROBABLE MYOCARDIAL INFARCTION</i></p> <p>Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><i>&lt; 5 min</i></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>[Signature] ATTENDING</i>		29c. License number <i>D 40390</i>		29d. Date signed (Month, Day, Year) <i>NOVEMBER 30, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>P.R. DESAI, MD; 28 CROSSROADS DR., # 305 OWINGS MILLS, MD 21117</i>									
31. Date filed (Month, Day, Year) <i>DEC - 1 2000</i>			32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>PAUL H BARBOUR JR.</i>				2. Date of Death Month <i>11</i> Day <i>27</i> Year <i>2000</i>		3. Time of Death <i>5:30 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Heritage Harbor Rehabilitation</i>				4b. City, Town, or Location of Death <i>Annapolis, MD</i>		4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>028-34-7046</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 7, 1914</i>		9. Birthplace (State or Foreign Country) <i>South Dakota</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Annapolis</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>45 Franklin Street</i>				10f. Zip Code <i>21401</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) <i>5+</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Physician</i>			16b. Kind of Business/Industry <i>Medicine</i>		
	17. Father's Name (First, Middle, Last) <i>Paul Humphrey Barbour</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Whitter Bailey</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Sandra Marie (Step-daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>179 Duke of Gloucester Street, Annapolis, MD 21401</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>11/29 2000</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>	
	21. Signature of Funeral Service Licensee <i>Michael P. Latta</i>				22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Premier</i> Due to (or as a consequence of): b. <i>coronary Artery disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <i>days.</i> <i>YRS</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>N. Tavaroh M.D.</i>		29c. License number <i>D41978</i>		29d. Date signed (Month, Day, Year) <i>11-27-2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>N. Tavaroh 1 Hosp Dr Llewelly M.D 20785</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>DEC - 1 2000</i>		32. Registrar's Signature <i>Denise B. Spence</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 26 per me G790 12/1/00 yf

## Certificate of Death

Reg. No.

00 38113

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ISABELLE BRAVMANN</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>12:00PM</b>	
4a. Facility Name (If not institution, give street and number) <b>MARRIOTT BRIGHTON GARDENS</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>216-80-3722</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP. 10, 1916</b>
9. Birthplace (State or Foreign Country) <b>ROMANIA</b>		10. Usual Residence of Decedent			
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>1840 REISTERSTOWN ROAD</b>			
10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>	
16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>AARON EDELSTEIN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>RACHEL MARKOWICZ</b>	
19a. Informant's Name/Relationship (Type, Print) <b>SIDNEY BRAVMANN / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4110 WINDRIDGE ROAD - BALTIMORE, MD 21208</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESD</b>		20c. Date <b>11/29/00</b>	
20d. Location - City or Town, State <b>RANDALLSTOWN, MD</b>		21. Signature of Funeral Service Licensee <i>Scott M. Little</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>FAILURE TO THRIVE</b> Due to (or as a consequence of):					
b. <b>END STAGE CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):					
c. <b>ARTERIOSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of):					
d.					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC ATRIAL FIBRILLATION</b>					
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Deborah I. Pierce</i>		29c. License number <b>H45931</b>		29d. Date signed (Month, Day, Year) <b>November 27, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deborah I. Pierce 7220 PARK HEIGHTS AVENUE BALTIMORE, MD</b>					
31. Date filed (Month, Day, Year) <b>EC - 1 2000</b>		32. Registrar's Signature <i>Benjamin S. Sparks</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38114

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARVEY BROWN</b>						2. Date of Death Month Day Year <b>NOVEMBER 22, 2000</b>			3. Time of Death <b>05:46 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VA MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-22-7530</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>JUNE 11, 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3105 HANLON AVE</b>				10f. Zip Code <b>21216</b>				10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2 YEARS</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CRANE OPERATOR</b>				16b. Kind of Business/Industry <b>AMERICAN SHELLING &amp; REFINING</b>				
17. Father's Name (First, Middle, Last) <b>HARVEY S. BROWN, SR.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN BROWN</b>						
19a. Informant's Name/Relationship (Type, Print) <b>LAURENCE BROWN / SON</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3105 HANLON AVE BALTIMORE, MARYLAND 21216</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUS MEMORIAL PARK</b>				Date <b>11-28-2000</b>		20c. Location - City or Town, State <b>ARBUS, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Gray Harris</b>						22. Name and Address of Facility <b>CHATHAM HOME'S GENERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>ACIDOSIS</b> Due to (or as a consequence of):  b. <b>PULMONARY HYPERTENSION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death  <b>1 DAY</b>  <b>1 WEEK</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>UROSEPSIS</b>											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <b>MD</b>		29c. License number <b>D13409</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 22, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOOYOUNG JULIA SHIN MD BVANC 101 N. GREENE ST. BALTIMORE, MD 21201</b>												
State Registrar		31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature <b>[Signature]</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38115

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eileen Theresa Busick						2. Date of Death Month Day Year November 27 2000		3. Time of Death 2300	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center						4b. City, Town, or Location of Death BelAir		4c. County of Death Harford	
Funeral Director	5. Social Security Number 212-34-4749		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 8/13/1936		9. Birthplace (State or Foreign Country) Balto. Md.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Harford		10c. City, Town or Location BelAir				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 307 D Laurel Woods Drive						10f. Zip Code 21009		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry her own Home		
	17. Father's Name (First, Middle, Last) James Joseph Kinsella						18. Mother's Name (First, Middle, Maiden Surname) Mary Josephine McQuire			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles Busick						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 D Laurel Woods Dr. BelAir, Md 21009			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		20c. Location - City or Town, State Baltimore, MD		20d. Date 12/1/00	
	21. Signature of Funeral Service Licensee E.F. Lassahn						22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Rd Kingsville, Md 21087			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation. Congestive heart failure. cellulitis.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier Attending						29c. License number D-16444		29d. Date signed (Month, Day, Year) NOVEMBER 28 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VIJAY S. NAIR M.D. 2112 Belair Road. Fallston. MD. 21047									
31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2000 NOV 31 AM 11:22

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38116

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frank Bruce</b>				2. Date of Death Month <b>November</b> Day <b>27</b> , Year <b>2000</b>				3. Time of Death <b>5:50 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>218-16-0217</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>November 14, 1924</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	10a. State <b>Maryland</b>				10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mt. Airy</b>			
To Be Completed by Funeral Director	10e. Street and Number <b>7909 Circle Drive</b>				10f. Zip Code <b>21771</b>				10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Meat Cutter</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>				16b. Kind of Business/Industry <b>Butcher</b>	
	17. Father's Name (First, Middle, Last) <b>Ferdinand Desoto Bruce</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lola Mae Hess</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Bruce/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7909 Circle Drive Mt. Airy, Maryland 21771</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>				20c. Location - City or Town, State <b>12-05-2000 Arlington, Virginia</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fleck Funeral Home</b> <b>7601 Sandy Spring Rd. Laurel, Maryland 20707</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):  <b>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):  <b>c. SMOKING</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death <b>30 DAYS</b> <b>4 YEARS</b> <b>4 YEARS</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ISCHEMIC HEART DISEASE</b> <b>CHRONIC PANCREATITIS</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D25947</b>		
29d. Date signed (Month, Day, Year) <b>NOVEMBER 27, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W. JACKSON, MD 346 OLIVARDO COURT, SUITE 200, OLNEY, MD 20832</b>				31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





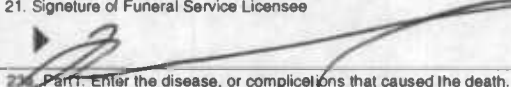
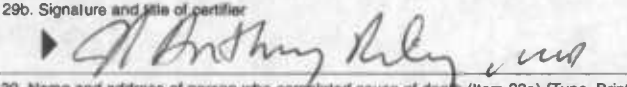

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38117

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY LOUISE BAKER</b>				2. Date of Death Month Day Year <b>NOVEMBER 28, 2000</b>				3. Time of Death <b>5:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GILCHRIST HOSPICE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>198-12-4815</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>09/15/1921</b>	
	9. Birthplace (State or Foreign) <b>MARYLAND</b>									
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>LOCH RAVEN VILLAGE</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1881 EDGEWOOD ROAD</b>				10f. Zip Code <b>21234-5207</b>				10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>				16b. Kind of Business/Industry <b>OWN HOME</b>	
	17. Father's Name (First, Middle, Last) <b>GEORGE W. STEPHENS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>RACHEL CHIPMAN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>WARREN W. BAKER / HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1881 EDGEWOOD RD; BALTIMORE, MD 21234-5207</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC.</b>		Date <b>11/29</b>		20c. Location - City or Town, State <b>CATONSVILLE, MD</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD.; BALTIMORE, MD 21286</b>					
	Physician /Medical Examiner	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>end-stage cardiomyopathy</b> Due to (or as a consequence of):  b. <b>coronary artery disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>months</b>  <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>renal failure</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley 6606 6701 N. Charles St. Balto. MD 21208</b>									
	31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature 							

2003 NOV 31 AM 9:57

Unknown 00-321

Joann Craig amend item 23a per ME  
amend item 20b per FH G790  
amend item 23a, pt II, 27, 28a, bc, d, e, f per the G790

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

G794 041301 SS

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38118

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOANN CRAIG</u>				2. Date of Death Month Day Year November 16 2000		3. Time of Death 06:55 A.M.	
	4a. Facility Name (If not institution, give street and number) 3540 South Hanover Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number UNKNOWN		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 41 Yrs.		8. Date of Birth (Month, Day, Year) 12-29-1958	
	Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
To Be Completed by Funeral Director	10e. Street and Number 4211 LIBERTY HEIGHTS AVENUE				10f. Zip Code 21217		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (13 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UK		16b. Kind of Business/Industry UK	
	17. Father's Name (First, Middle, Last) UK				18. Mother's Name (First, Middle, Maiden Surname) ARLENE DAVIS			
	19a. Informant's Name/Relationship (Type, Print) JESSE GOOLESBY / BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4211 LIBERTY HGTS. AVE. BALTO. MD. 21217			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY CREMATION SERVICES		Date 11-27-00		20c. Location - City or Town, State BALTO. MD	
	21. Signature of Funeral Service Licensee <u>Vaughn C H</u>				22. Name and Address of Facility CREMATION SERVICES 5151 BALTO. NATL PIKE, BALTO. MD. 21229			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ALCOHOL INTOXICATION AND ACUTE PANCREATITIS COMPLICATED BY HYPOTHERMIA a. <u>ALCOHOL INTOXICATION COMPLICATED BY HYPOTHERMIA</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CIRRHOSIS OF LIVER AND CHRONIC ALCOHOLISM							
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found 11/16/00		28b. Time of Injury found 6:53 A		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) other residence				28d. Describe how injury occurred unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and Title of certifier <u>Theodore H</u>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 16, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) DEC - 1 2000				32. Registrar's Signature <u>Benjamin B Sparks</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27,28a,b,c,d,e,f per me G790 12/7/00 y Certificate of Death

Reg. No.

00 38119

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID VALENTINO CARTER JR.</b>						2. Date of Death Month Day Year <b>November 18 2000</b>		3. Time of Death <b>10:34 A.M.</b>			
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>217-20-7535</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5-6-59</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BAITIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1953 W. PATTERSON PARK AVE</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>CONSTRUCTION</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>DAVID V. CARTER SR.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>BERNETHA TYNES</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>BERNETHA TYNES CARTER MOTHER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1953 N PATTERSON PARK AVE, BALTIMORE, MD 21213</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEM.</b>		20c. Date <b>Nov 30 2000</b>		20d. Location - City or Town, State <b>BALTO. MD.</b>					
	21. Signature of Funeral Service Licensee <b>Carlton C. Douglass</b>		22. Name and Address of Facility <b>CARLTON C. DOUGLASS FUNERAL SER. 1701 MCCULLOH ST. - BALTO. MD. 21217</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
											24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found: 11/18/00</b>		28b. Time of Injury <b>found: 9:30 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found residence</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1953 N. Patterson Park Avenue Baltimore, Maryland</b>			
	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
State Registrar	29b. Signature and title of certifier <b>Dr. Wayne McPherson</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 19, 2000</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MD Registrar P. Korosh 111 Penn Street, Baltimore, Maryland 21201</b>											
	31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>P. Korosh</b>									

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7,8 per FHG790 12/4/2000 EW

## Certificate of Death

Reg. No.

00 38120

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabella Catherine Cole

2. Date of Death

November 30 2000

3. Time of Death

9:15 a.m.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214 14 7386

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 29, 1916

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

4 Yes 2 No

10e. Street and Number

8632 Oak Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Angus White

18. Mother's Name (First, Middle, Maiden Surname)

Vernie Gross

19a. Informant's Name/Relationship (Type, Print)

Brenda Ford/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8632 Oak Road Baltimore County, Maryland 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

The Green Mount Cemetery

Date

December 1, 2000

20c. Location (City or Town, State)

Baltimore City, Maryland

21. Signature of Funeral Service Licensee

Margaret Gilmore Henson

22. Name and Address of Facility

Mortician 5340 Riggstown Road Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Cardiac Arrhythmia

Due to (or as a consequence of):

b.

ACVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, PEG,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margaret C. Raymond MD

29c. License number

054518

29d. Date signed (Month, Day, Year)

12/1/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTHA C. RAYMOND 3004 E Northern Parkway Baltimore MD 21214

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38121

AMEND ITEM: 8 PER F.H. G790 12-1-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Carson</u>				2. Date of Death Month <u>November</u> Day <u>22</u> Year <u>2000</u>				3. Time of Death <u>2:00 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital</u>				4b. City, Town, or Location of Death <u>Randallstown</u>				4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>212 28 4390</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>83</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <u>Feb. 15, 1917</u>	9. Birthplace (State or Foreign Country) <u>South Carolina</u>			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <u>Maryland</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>BALTIMORE</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <u>2815 WALBROOK AVE</u>				10f. Zip Code <u>21216</u>		10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th grade</u>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housekeeper</u>			16b. Kind of Business/Industry <u>University of Maryland Hospital</u>		
	17. Father's Name (First, Middle, Last) <u>unk.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>ROSIE SKETT</u>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Gloria Miller / Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2815 WALBROOK AVE BALTIMORE, MD 21216</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Crowsville Veterans Cemetery</u>		Data <u>11-28-2000</u>		20c. Location - City or Town, State <u>Crowsville, Maryland</u>			
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>CHATHAM - HARRIS Funeral Home</u> <u>5240 REISTERSTOWN ROAD</u> <u>BALTIMORE, MARYLAND 21215</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>Colon Cancer</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension, Coronary Artery Disease</u>										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Christopher J. Davis</u>		29c. License number <u>#D0055609</u>		29d. Date signed (Month, Day, Year) <u>November 22, 2000</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Christopher J. Davis M.D. 2401 West Belvedere Avenue Baltimore, Maryland 21215</u>										
31. Date filed (Month, Day, Year) <u>DEC - 1 2000</u>		32. Registrar's Signature <u>[Signature]</u>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38122

AMEND ITEM: #14 PER F.H. G790 12-1-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OSCAR GERARDO CHIDICHIMO</b>			2. Date of Death Month Day Year <b>November 05, 2000</b>		3. Time of Death <b>745 am</b>		
	4e. Facility Name (If not institution, give street and number) <b>Westbound Interstate 70 at Blackrock Road</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>589-03-7291</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b>	8. Date of Birth (Month, Day, Year) <b>JULY 1, 1955</b>		9. Birthplace (State or Foreign Country) <b>ARGENTINA</b>		
	Usual Residence of Decedent			10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10a. State <b>FLORIDA</b>		10b. County <b>DADE</b>		10c. City, Town or Location <b>MIAMI</b>				
10e. Street and Number <b>17610 NE 2nd COURT</b>			10f. Zip Code <b>33162</b>		10g. Citizen of What Country? <b>ARGENTINA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>ARGENTINIAN</b>		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRESIDENT</b>		16b. Kind of Business/Industry <b>PRINTING INDUSTRY</b>			
17. Father's Name (First, Middle, Last) <b>ANGEL CHIDICHIMO</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARIA GIOIA</b>					
19a. Informant's Name/Relationship (Type, Print) <b>SERGIO CHIDICHIMO (SON)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17610 NE 2nd COURT, MIAMI, FL. 33162</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. LINCOLN CREMATORY</b>		20c. Location - City or Town, State <b>11/28/00 BRENTWOOD, MARYLAND</b>			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>LOUDON PARK FUNERAL HOME 3620 WILKENS AVE., BALTIMORE, MD 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <b>11/5/00</b>		28b. Time of Injury <b>605A M</b>		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred <b>Driver of Tractor-trailer in vehicular accident</b>			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>I-70 W / Blackrock Rd</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 06, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LARON LOKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>			32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38123

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LORETTA NATEALIE COSTELLO</b>				2. Date of Death Month Day Year <b>NOV. 27, 2000</b>		3. Time of Death <b>10:45am</b>		
	4a. Facility Name (If not institution, give street and number) <b>ST. ELIZABETHS NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death		
Funeral Director	5. Social Security Number <b>217-22-2490</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 16, 1904</b>		
	9. Birthplace (State or Foreign Country) <b>MASSACHUSETTS</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>1108 PLOVER DRIVE</b>		10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+) <b>HOMEMAKER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>			
17. Father's Name (First, Middle, Last) <b>PETER GAGNE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSEALIE (UNKNOWN)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MARGUERITE L. KRACH (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1108 PLOVER DR., BALTIMORE, MD 21227</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		Date <b>11/30/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LOUDON PARK FUNERAL HOME</b> <b>3620 WILKENS AVE., BALTIMORE, MD 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>END STAGE PARKINSON'S DISEASE</b> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC DEPRESSION, MULTI-INFARCT</b> <b>DEMENTIA, CORONARY HEART DISEASE</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Attending</b>		29c. License number <b>D16200</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NORBERTO M. MACHIRAN, M.D., 720 MAIDEN CHOICE LANE, CATONSVILLE, MD 21228</b>		31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #7 PER F.H. G791 1-18-01 WR.

## Certificate of Death

Reg. No.

00 38124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene Di Cocco</b>				2. Date of Death Month <b>November</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>4:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>1404 B Bonnett Place</b>				4b. City, Town, or Location of Death <b>Belair</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>232-96-7738</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>107</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3-8-1893</b>	
	9. Birthplace (State or Foreign Country) <b>Italy</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Belair</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1404 B Bonnett Place</b>		10f. Zip Code <b>21015</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>In own home</b>		
17. Father's Name (First, Middle, Last) <b>John Di Carlo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Domenica Sperduti</b>				
19a. Informant's Name/Relationship (Type, Print) <b>daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1404 B Bonnett Place, Belair, Maryland 21015</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entomb.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>11/30/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Maria N. Zannino</b>				22. Name and Address of Facility <b>Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St., Baltimore, Maryland 21224</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Thoracic Aortic Aneurysm</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. <b>Coronary Artery Disease</b> Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Stephen G. Sullivan, MD</b>				29c. License number <b>144583</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen G. Sullivan, MD 2021 Emmorton Rd, suite 114 Belair, MD 21015</b>								
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>Beverly B. Spores</b>						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38125

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nora Devine

2. Date of Death

Nov 21 2000

3. Time of Death

7:10 AM

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

206-20-0233

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec 19, 1911

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6391 Rowanberry Drive

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

waitress

16b. Kind of Business/Industry

restaurant

17. Father's Name (First, Middle, Last)

James Foy

18. Mother's Name (First, Middle, Maiden Surname)

Bridget Grady

19a. Informant's Name/Relationship (Type, Print)

John Devine/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

406 St. Ives Drive Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Days

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Hours

Due to (or as a consequence of):

c. Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael E. Silverman, MD

29c. License number

D41274

29d. Date signed (Month, Day, Year)

Nov 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael E Silverman, MD Howard Co General Hosp Columbia, MD 21044

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

B. Sparks

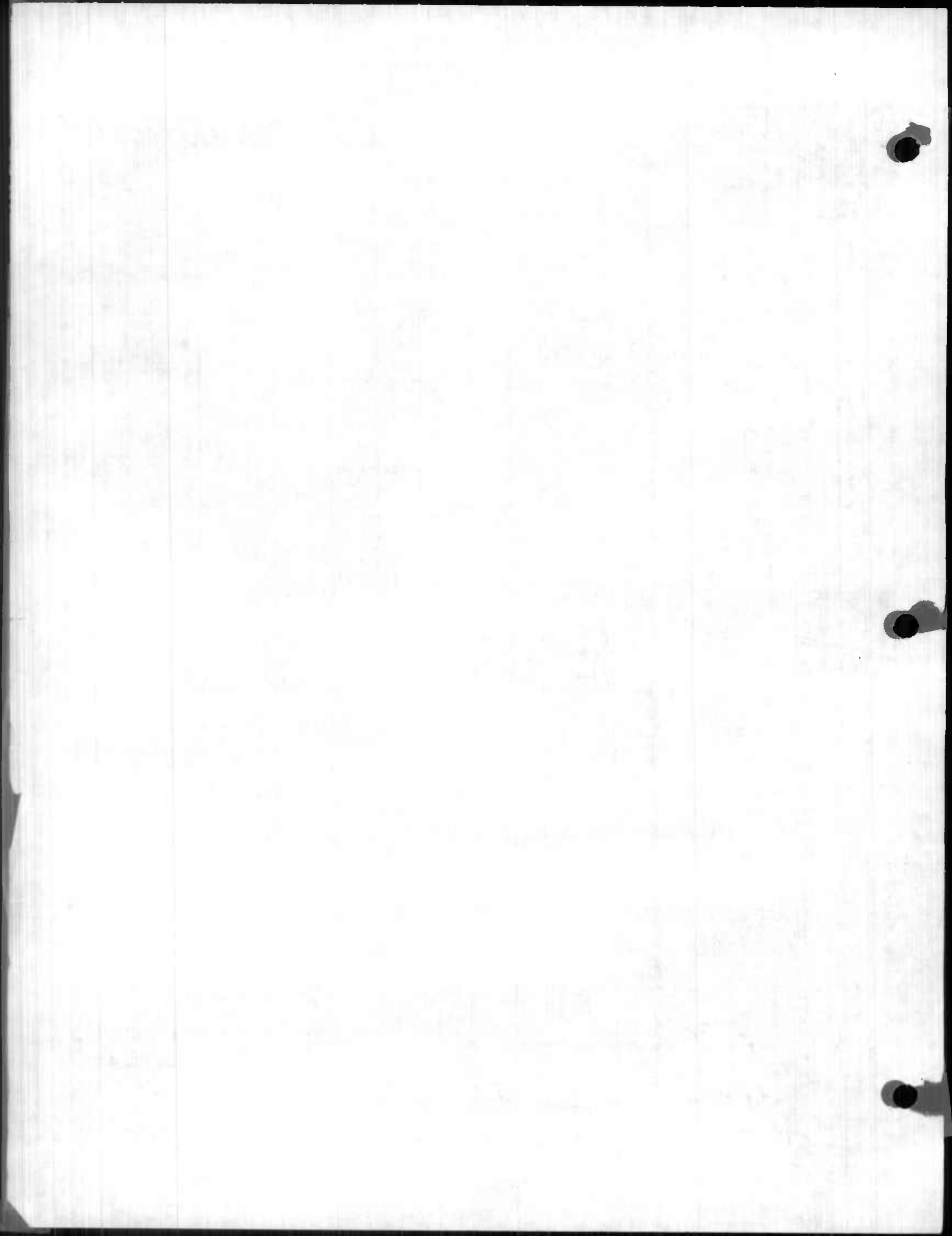
State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEMS: #27, 28A-F PER MEO G793 3-20-01

Certificate of Death

Reg. No.

00 38126

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>GORDON S DILLARD</b>		2. Date of Death Month <b>11</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>2:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
5. Social Security Number <b>217-52-8490</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 19, 1950</b>
9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent			
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4108 Glenhunt Road</b>			
10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>bank teller</b>		16b. Kind of Business/Industry <b>financial</b>			
17. Father's Name (First, Middle, Last) <b>Gordon Scott Dillard</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Gwendolyn Sterling</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Shirley Dillard/stepmother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4108 Glenhunt Road Baltimore, MD 21229</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Anoxic ENCEPHALOPATHY</b> Due to (or as a consequence of): <b>b. DRUG OVERDOSE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>11, 19 2000</b>		28b. Time of Injury <b>UNK.</b> M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>UNKNOWN</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D24100</b>		29d. Date signed (Month, Day, Year) <b>11-22-2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. L. PRASHAK ARMED 300 ARMAN PLACE BAL</b>					
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>			



00 38127

DHHH 16 Rev 6/95



WARREN

State of Maryland / Department of Health and Mental Hygiene

00 38128

DIXON amend item 23a,27 per me G790 12/7/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WARREN S. DIXON				2. Date of Death Month Day Year NOVEMBER 29, 2000				3. Time of Death 10:16P.M.	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death n/a	
Funeral Director	5. Social Security Number 216-54-3622		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) March 14 1946		9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1309 Patapsco Street		10f. Zip Code 21230		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Advnet Senior Center					
	17. Father's Name (First, Middle, Last) Loring Dixon				18. Mother's Name (First, Middle, Maiden Surname) Ann Hause					
	19a. Informant's Name/Relationship (Type, Print) Darlene Alleman (Sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Valcour Road, Baltimore, Md. 21228					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park		20c. Date 12/04/2000		20d. Location - City or Town, State Glen Burnie, MD.			
	21. Signature of Funeral Service Licensee <i>Richard Pickett</i>				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND BICUSPID a. AORTIC VALVE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i> 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) NOVEMBER 30, 2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPKE, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) DEC - 1 2000 32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38129

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernice C. Dennis</b>				2. Date of Death 17 <sup>th</sup> 30 <sup>th</sup> 2000 <sup>Year</sup>		3. Time of Death 7:55 am		
	4e. Facility Name (If not Institution, give street and number) <b>Maryland Masonic Homes</b>				4b. City, Town, or Location of Death <b>Cockeysville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-18-3741</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 28, 1917</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>300 International Cir.</b>		10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Envelope</b>					
17. Father's Name (First, Middle, Last) <b>William Ellsworth Harden, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Myrtle Brooks</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Robert M. Harden/Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3532 Keswick Road Baltimore, MD 21211</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park Cemetery</b>		20c. Date <b>Dec. 4, 2000</b>		20d. Location - City or Town, State <b>Elkridge, MD</b>			
21. Signature of Funeral Service Licensee  <b>Michael J. Flagle</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093</b>					
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (First disease or condition resulting in death) <b>a. Atherosclerotic Vascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>Years.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes, Dementia, Coronary Artery Disease</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>R. Liberto, M.D.</b>		29c. License number <b>D21464</b>		29d. Date signed (Month, Day, Year) <b>11/30/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3708 Bmw St Bldg, Apt 21224, Robert Liberto, MD.</b>									
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

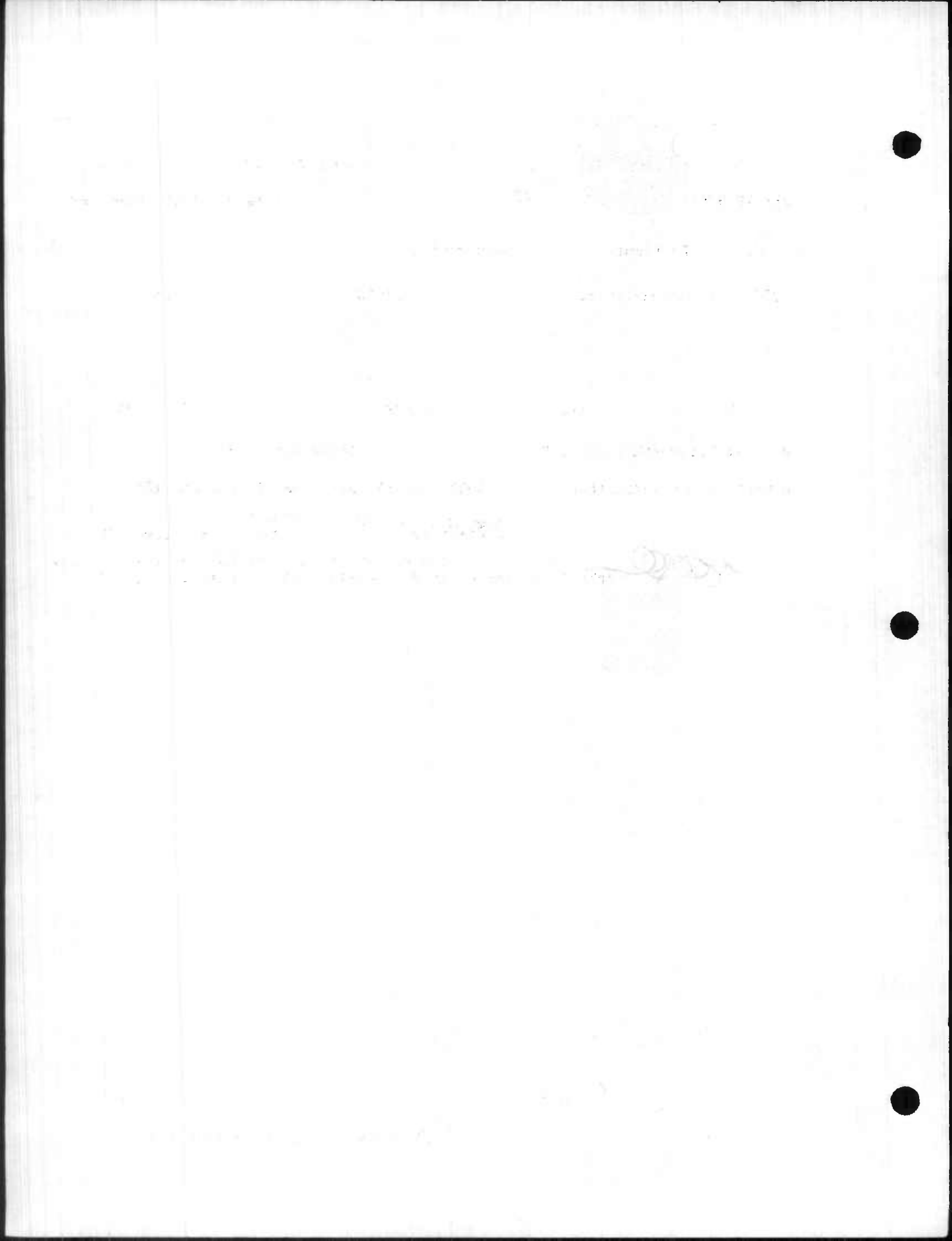
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38130

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JERRY LEWIS FLOOD</b>				2. Date of Death Month Day Year <b>November 21 2000</b>		3. Time of Death <b>00:30 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>1316 North Luzerne Avenue</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>217-66-2924</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 15, 1958</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <b>1 Yes 2 No</b>	
	10e. Street and Number <b>1316 N. LUZERNE AVE</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>14 GR</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REAGER</b>		16b. Kind of Business/Industry <b>Maryland Drydock and Ship Building</b>				
	17. Father's Name (First, Middle, Last) <b>WILLIE M. FLOOD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY INEZ MCNETT</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>WILLIE M. FLOOD / Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1904 BOONE STREET BALTIMORE, Maryland 21218</b>				
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENMOUNT CEMETERY</b>		Date <b>12-1-2000</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee <b>Gregory Harris</b>		22. Name and Address of Facility <b>CHATHAM - Horn's F.H. 5240 REISTERSTOWN ROAD BALTIMORE, Md 21215</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cocaine and Narcotic Intoxication Complicated By</b> Due to (or as a consequence of): <b>b. Severe Dehydration and Thermal Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b> <b>X</b>								
State Registrar	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) Scene</b>				
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>12/01/00</b>		28b. Time of Injury <b>2:33 AM</b>		28c. Injury at Work? <b>1 Yes 2 No</b> <b>X</b>		28d. Describe how injury occurred <b>subject drunk on the vehicle in hospital</b>
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1316 North Luzerne Avenue Baltimore</b>						
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>								
	29b. Signature and title of certifier <b>Therese M. King</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 21, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Therese M. King</b> <b>11 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>				32. Registrar's Signature <b>James B. Sparks</b>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38131

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET K. FULTON

2. Date of Death  
Month Day Year  
NOVEMBER 27, 20003. Time of Death  
1:07 AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince Georges

5. Social Security Number

220-10-4361

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 26, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12914 Cresap Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
516a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

hair stylist

16b. Kind of Business/Industry

cosmotology

17. Father's Name (First, Middle, Last)

Winston C. Fulton

18. Mother's Name (First, Middle, Maiden Surname)

Cora L. Pierce

19a. Informant's Name/Relationship (Type, Print)

Barbara Davis/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12206 Riverview Road Fort Washington, MD 20744

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):b. Hypertensive Cardiovascular Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Upper Gastrointestinal  
Bleed, Congestive Heart Failure  
Abdomen Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Ronald S. Wade

29c. License number

D37066

29d. Date signed (Month, Day, Year)

11-27-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Uchechi T. Opaigboye, M.D.

4467 Old Branch Avenue, #105  
Temple Hills, MD 20748

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38132

AMEND ITEM: #10E PER F.H. G790 12-11-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN</b>				2. Date of Death Month <b>11</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>11:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Ctr.</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218-28-6938</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 4, 1932</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>				10d. Inside City Limits <b>1 Yes 2 No</b>			
10e. Street and Number <b>2008 PAULETTE RD. APT. 1</b> <b>7915 St. Claire Lane</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>				14. Race - American Indian, Black, White, etc. <b>Specify: White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10 Years</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>				16b. Kind of Business/Industry <b>Fairlanes</b>			
17. Father's Name (First, Middle, Last) <b>Theodore Schott, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Christine Brandt</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Phyllis Franks (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2008 Paulette Road Apt. 1 Dundalk, Maryland 21222</b>							
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gdns.</b>		Date <b>12/4/2000</b>		20c. Location - City or Town, State <b>Bel Air, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Obesity hyperventilation syndrome</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>										Approximate Interval Between Onset and Death <b>5 yrs</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
								24a. Was an autopsy performed? <b>1 Yes 2 No</b>			
								24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>			
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>			
				28d. Describe how injury occurred							
				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
29b. Signature and title of certifier 				29c. License number <b>RES-000</b>				29d. Date signed (Month, Day, Year) <b>NOVEMBER 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Philip Nivatun, 600 N. Wolfe St, Nelson 106, Baltimore, MD 21287</b>											
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38133

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE J. FEUERHARDT JR						2. Date of Death Month Day Year NOVEMBER 21, 2000		3. Time of Death 2:45 PM	
	4a. Facility Name (If not institution, give street and number) JOSEPH RITCHEY HOSPICE						4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 219-22-8531		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Mar 16, 1928		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 613 Belnord Avenue				10f. Zip Code 21205		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) warehouse			16b. Kind of Business/Industry grocery			
17. Father's Name (First, Middle, Last) George J. Feuerhardt Sr						18. Mother's Name (First, Middle, Maiden Surname) Nellie Webber				
19a. Informant's Name/Relationship (Type, Print) Dale Feuerhardt/daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3566 Horton Ave Baltimore, MD 21225				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic carcinoma, unknown primary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1 month
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Anemia Coagulopathy							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Brent Macdonald		29c. License number D47105		29d. Date signed (Month, Day, Year) 11/21/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brent Macdonald MD 2400 KIRK AVE. Balt, MD 21218										
31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature B. Sparks								



JOANNE

State of Maryland / Department of Health and Mental Hygiene

FUTERAL amend item 23a,27,28a,b,c,d,ef, per me G791 **Certificate of Death**

Reg. No.

00 38134

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joanne Michelle Futeral</b>						2. Date of Death Month Day Year <b>NOVEMBER 28, 2000</b>		3. Time of Death <b>11:40A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>112 E. PRESTON STREET</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-48-5966</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 14, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10a. Street and Number <b>112 E. Preston Street</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 years</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesperson</b>			16b. Kind of Business/Industry <b>Ballpark</b>			
17. Father's Name (First, Middle, Last) <b>John Michael Herbert, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Alba R. Fabre</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Allison Futeral/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3232 Encinal Avenue Alameda California 94501</b>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Date <b>12/01/00</b>		20c. Location - City or Town, State <b>Towson Maryland</b>		
21. Signature of Funeral Service Licensee <b>Christina L. Hilton</b> <i>Christina L. Hilton</i>				22. Name and Address of Facility <b>Leonard J. Ruck, Inc.</b> <b>5305 Harford Rd. Baltimore MD 21214</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) <b>PROPOXYPHENE INTOXICATION</b>									
	Due to (or as a consequence of):									
	Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>								
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11/28/00</b>		28b. Time of Injury <b>found 11:30 A M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred decedent ingested drugs		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>112 E. Preston Street Baltimore, Maryland</b>								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 29, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature <i>[Signature]</i>							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38135

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gradis Felder</b>				2. Date of Death Month: <b>November</b> Day: <b>27</b> Year: <b>2000</b>		3. Time of Death <b>11:42 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>866 Exeter Hall Avenue</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-32-3912</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 19, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>South Carolina</b>						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>866 Exeter Hall Ave.</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (14 or 5+): <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction</b>		16b. Kind of Business/Industry <b>Self Employed</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Herman Felder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Daisy Allen</b>		
	19a. Informant's Name/Relationship (Type, Print) (Brother) <b>Rev. Willie Williams</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>837 Mt. Holly St. Balto. Md. 21229</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>							Approximate Interval Between Onset and Death
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify):					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>J. A. [Signature]</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 27, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38136

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES ALBERT GORE</b>			2. Date of Death Month Day Year <b>NOVEMBER 28 2000</b>		3. Time of Death <b>1530</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>			4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>237-44-4839</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR-12-1934</b>	
	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5720 WAINWRIGHT AVE</b>		10f. Zip Code <b>20851</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>AUTO</b>		17. Father's Name (First, Middle, Last) <b>JOHN D. GORE</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>SALLY SCOTT</b>		19a. Informant's Name/Relationship (Type, Print) <b>ROWENA GORE SIMMONS (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5720 WAINWRIGHT AVE - ROCKVILLE, MD. 20851</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. Date <b>12-2-00</b>		20d. Location - City or Town, State <b>BALTO. MD</b>		21. Signature of Funeral Service Licensee <b>Carlton C. Douglass</b>	
	22. Name and Address of Facility <b>CARLTON C. DOUGLASS FUNERAL SERVICE</b>		22b. Address <b>1701 MCGUIRE ST BALTO. MD. 21217</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SHOCK</b> Due to (or as a consequence of): <b>MULTISYSTEM FAILURE</b> <b>SEPSIS</b> <b>PNEUMONIA</b>		Approximate Interval Between Onset and Death <b>10 DAYS</b> <b>1 MONTH</b> <b>1 MONTH</b> <b>1 MONTH</b>	
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MALNUTRITION</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27a. Date of Injury (Month, Day Year)		27b. Time of Injury <b>M</b>	
To Be Completed by Physician/Medical Examiner	27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27d. Describe how Injury occurred		27e. Location (Street and Number or Rural Route Number, City or Town, State)		27f. Location (Street and Number or Rural Route Number, City or Town, State)	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Location (Street and Number or Rural Route Number, City or Town, State)		28c. Location (Street and Number or Rural Route Number, City or Town, State)		28d. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael J. ...</b>		29c. License number <b>230112</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 28 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VIRENDRA K. SAXENA MD 15600 MARATHON CIRCLE #301 GAITHERSBURG MD 20878</b>		31. Data filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		33. Registrar's Signature <b>B. Sparks</b>	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38137

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEANETTE GRIFFIN</b>						2. Date of Death Month <b>NOVEMBER</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>12:45P</b>			
	4a. Facility Name (If not institution, give street and number) <b>GARDENVIEW</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
Funeral Director	5. Social Security Number <b>220-03-8344</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1917</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
	Usual Residence of Decedent						10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						10e. Street and Number <b>5102 Belleville Avenue</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAN</b>	
	16b. Kind of Business/Industry <b>BOARD OF EDUCATION</b>		17. Father's Name (First, Middle, Last) <b>WILLIAM CLARK</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CLARK</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Raymond Clark/Brother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5102 Belleville Avenue, Baltimore, Maryland 21207</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. Location - City or Town, State <b>12-6-00 WOODLAWN, MARYLAND</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>chronic renal failure</b>										Approximate Interval Between Onset and Death <b>5 yr</b>	
	Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Arteriosclerotic cardio vascular disease</b>										<b>15 yr</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>MIAN K. D. [unclear]</b>		29c. License number <b>031865</b>		29d. Date signed (Month, Day, Year) <b>11/29/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rm 206 821 North Center Street Balt Md 21201</b>		31. Data filed (Month, Day, Year) <b>DEC - 1 2000</b>		
32. Registrar's Signature <i>[Signature]</i>												

JEANETTE GRIFFIN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

2000 NOV 31 PM 2:55



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38138

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Orville Fred Green

2. Date of Death

Nov 30 2000

3. Time of Death

2145

4a. Facility Name (If not institution, give street and number)

7963 Foster Ave

4b. City, Town, or Location of Death

Severn

4c. County of Death

AA

Funeral  
Director

5. Social Security Number

267-38-3853

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 22, 1926

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7963 Foster Ave.

10f. Zip Code

21144

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Heating Oil Delivery

17. Father's Name (First, Middle, Last)

Claude Green

18. Mother's Name (First, Middle, Maiden Surname)

Flossie Collins

19a. Informant's Name/Relationship (Type, Print)

Carolyn C. Wolf / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7963 Foster Ave., Severn, Maryland 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Mem. Park

Date

Dec. 4

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Cardiac Arrhythmia

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Alcoholism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

11/30/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD 675 America 81035

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

RESEARCH REPORT

NO. 1

1950

CHICAGO, ILL.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

RESEARCH REPORT

NO. 2

1951

CHICAGO, ILL.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

RESEARCH REPORT

NO. 3

1952

CHICAGO, ILL.

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38139

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G790 12-1-00

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>MARTIN GRIFFIN, Sr.</i>				2. Date of Death Month Day Year NOVEMBER 24 2000				3. Time of Death 8:05 A		
	4a. Facility Name (If not institution, give street and number) 3412 PARK HEIGHTS AVE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-52-1524		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Jan 16, 1949		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3412 Park Heights Ave				10f. Zip Code 21215		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) 10th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator		16b. Kind of Business/Industry General Repacking						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Eugene Griffin				18. Mother's Name (First, Middle, Maiden Surname) Sarah Miller						
	19a. Informant's Name/Relationship (Type, Print) Dorothy Griffin / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5412 Park Heights Ave Baltimore, Md 21215						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 11/29/2000		20c. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility CHATHAM HOME Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NARCOTIC AND ALCOHOL INTOXICATION a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) FOUND: 11-24-00				28b. Time of Injury UNKNOWN M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME				28d. Describe how injury occurred UNKNOWN							
28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MD 3412 PARK HEIGHTS AVE.											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) NOVEMBER 24, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LARON LOCKE, MD				111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) NOV 30 2000				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38140

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Marie Goodman

2. Date of Death

Nov. 29 2000

3. Time of Death

8:05 am.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2830 Old Taneytown Rd.

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

218-62-5548

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 22, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2830 Old Taneytown Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Arthur Ledford

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Marie Martin

19a. Informant's Name/Relationship (Type, Print)

Donnie Joe Goodman Sr. - husband 2830 Old Taneytown Rd. Westminster, Md. 21157

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LakeView Mem. Park Dec. 1, 2000

Date

20c. Location - City or Town, State

Sykesville, Md.

21. Signature of Funeral Service Licensee

J. South Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel P.A.  
11605 Reisterstown Rd. Owings Mills, Md. 2111723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Cor Pulmonale  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Severe Emphysema  
Due to (or as a consequence of):c. Pulmonary Hypertension  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anorexia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

J38488

29d. Date signed (Month, Day, Year)

11/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Uggowitzer 4500 Black Rock Rd, Hampstead, Md. 21074

State  
Registrar

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38141

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Craig Allen Hess</b>				2. Date of Death Month <b>November</b> Day <b>27</b> Year <b>2000</b>				3. Time of Death <b>03:00 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>1000 E Noland Drive</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>				4c. County of Death <b>Washington</b>				
Funeral Director	5. Social Security Number <b>235.17.9286</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>23</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 9, 1977</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>				
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State <b>WV</b>		10b. County <b>Berkeley</b>		10c. City, Town or Location <b>Martinsburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>318 Garden Drive</b>				10f. Zip Code <b>25401</b>				10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Production</b>				16b. Kind of Business/Industry <b>Book Bindery</b>				
	17. Father's Name (First, Middle, Last) <b>William Craig Hess</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Debby Koncer</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Pauline Usak Hess/Grandmother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>651 E. Burke Street Martinsburg, WV 25401</b>								
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rosedale</b>		Date <b>12/1</b>		20c. Location - City or Town, State <b>Martinsburg, WV</b>						
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary L. Kaufman Funeral Home at Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, Maryland 21075</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Intra-Oral Gunshot Wound</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <b>partial</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>											
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Formed 11-27-00</b>		28b. Time of Injury <b>07:30 A.M.</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>self-inflicted gunshot wound</b>					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1000 E. Noland Drive Hagerstown, MD</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Dennis Chute</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 28, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature  <b>B. Sparks</b>											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-638-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38142

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Norma Jean Hamburg					2. Date of Death Month Day Year November 28, 2000			3. Time of Death 7:06 PM		
	4a. Facility Name (If not institution, give street and number) 2029 Windsong Drive					4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington		
Funeral Director	5. Social Security Number 218-50-4307		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) May 31, 1940		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2029 Windsong Drive				10f. Zip Code 21740			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Collegiate (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife			16b. Kind of Business/Industry none			
	17. Father's Name (First, Middle, Last) Percy M. Sweeney					18. Mother's Name (First, Middle, Maiden Surname) Hazel L. Snapp					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) unk				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Ronald S. Wad, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Acute myocardial infarction Due to (or as a consequence of): b. Atherosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.										6 hrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease Hypertension								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number D44996		29d. Date signed (Month, Day, Year) November 29, 2000					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Zafar Malik MD 20311 Lappans Rd Boonsboro, MD 21713											
31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature Benjamin B. Sparks									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38143

Amended Items#1,17 perAB,Phy G791 1/18/2001 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE HAGER Hager				2. Date of Death Month Day Year November 20, 2000		3. Time of Death 0820	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 234-58-7720		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) July 11, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	Usual Residence of Decedent 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 14014 Marsh Pike		10f. Zip Code 21742	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) disabled				16b. Kind of Business/Industry none		17. Father's Name (First, Middle, Last) John Wesley Hager Hager	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) unk				19a. Informant's Name/Relationship (Type, Print) Rebecca Grove/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Salem Avenue Hagerstown, MD 21740	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility IIAM 1232 Mid-Valley Drive Jessup, PA 18434			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence of): Anterior ischemic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 10 min			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage renal disease with metabolic chronic obstructive pulmonary disease Peripheral vascular disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 29c. License number D18019 29d. Date signed (Month, Day, Year) Nov 21, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740				31. Date filed (Month, Day, Year) DEC 1 2000			
State Registrar	32. Registrar's Signature B. Sparks				33. Date of Death November 20, 2000			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38144

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joan M. Homa

2. Date of Death

November 28 2000

3. Time of Death

1:00 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie MD Anne Arundel

4c. County of Death

5. Social Security Number

164-24-1957

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/14/1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

632 West Moreland Place

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

John Leonard

18. Mother's Name (First, Middle, Maiden Surname)

Marie Nevitsky

19a. Informant's Name/Relationship (Type, Print)

John C. Homa (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

632 West Moreland Place, Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

11/30  
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Michael D. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis of liver  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

NAD

29c. License number

D48977

29d. Date signed (Month, Day, Year)

November 28 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela D. Smith, 301 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

State  
Registrar

JOAN HOMA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38145

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles D. Halstead				2. Date of Death Month Day Year November 28, 2000				3. Time of Death 2:00 P.M.				
	4a. Facility Name (If not institution, give street and number) 5917 Tamar Drive Apt. 4				4b. City, Town, or Location of Death Columbia				4c. County of Death Howard				
Funeral Director	5. Social Security Number 234-32-7651		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Aug. 8, 1924		9. Birthplace (State or Foreign Country) W. VA.		
	Usual Residence of Decedent												
10a. State MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 5917 Tamar Drive				10f. Zip Code 21045				10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Manager				16b. Kind of Business/Industry Food Service					
17. Father's Name (First, Middle, Last) Unk.						18. Mother's Name (First, Middle, Maiden Surname) Unk.							
19a. Informant's Name/Relationship (Type, Print) Katherine Halstead - Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5917 Tamar Drive Apt. 4 Columbia, MD 21045							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington Crem				Date 11/30/2000		20c. Location - City or Town, State Laurel, MD			
21. Signature of Funeral Service Licensee Dorothy Schen				22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045									
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)												15 years	
Due to (or as a consequence of):												5 years	
Due to (or as a consequence of):												5 years	
Due to (or as a consequence of):												10 years	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Rita E. King MD F.A.C.C.				29c. License number D0037155		29d. Date signed (Month, Day, Year) Nov, 30, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rita E. King 11085 Little Patuxent Parkway Columbia, MD 21044													
31. Date (Month, Day, Year) DEC 1 2000				32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38146

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Charles Hicken				2. Date of Death Month Day Year November 29, 2000				3. Time of Death 2:15 PM	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford	
Funeral Director	5. Social Security Number 220-07-1905		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 203 J. Burkwood Ct.				10f. Zip Code 21015		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12      College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Adjuster			16b. Kind of Business/Industry MD State Gov.		
	17. Father's Name (First, Middle, Last) Harry Charles Hicken, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Edith Madda				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Hilda Hicken (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 J. Burkwood Ct. Bel Air, MD 21015					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 12/2/2000		20d. Location - City or Town, State Woodlawn, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Burrier-Queen Funeral Directors, PA. 1212 West Old Liberty Rd. Winfield, DM 21784					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) pneumonia Respiratory failure Due to (or as a consequence of): Cerebrovascular accident Due to (or as a consequence of): Anterograde vascular disease Due to (or as a consequence of): Dementia									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier  M.D.				29c. License number D200661		29d. Date signed (Month, Day, Year) 11/29/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Lee MD 669 Revolution St. Harford MD 21078										
31. Date filed (Month, Day, Year) DEC - 1 2000				32. Registrar's Signature 						

ORIGINAL

2000 NOV 31 AM 10:51



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38147

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Lee Horsley				2. Date of Death Month: Nov Day: 13 Year: 2000				3. Time of Death 6:58AM	
	4a. Facility Name (If not institution, give street and number) Mariner Health Care Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 226-86-6380		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) March 16 1955		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State VA		10b. County Fairfax		10c. City, Town or Location Alexandria				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7963 Richmond Hwy #22				10f. Zip Code 22306		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction				16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Raymond Lee Horsley				18. Mother's Name (First, Middle, Maiden Surname) Rosa Mae Horsley					
	19a. Informant's Name/Relationship (Type, Print) Sheila Heflin Horsley /Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7963 Richmond Hwy #22 Alex. VA 22306					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery		Date 11/20/00		20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee [Signature] MC1141				22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Vascular Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure, Cerebrovascular Ischemia, Hypertension									
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number D0046374		29d. Date signed (Month, Day, Year) 11/15/2000			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Anthony D. [Signature] 1328 Southern Ave SE #312 Washington DC 20032									
31. Date filed (Month, Day, Year) DEC - 1 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38148

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George William Howard</b>				2. Date of Death Month Day Year <b>Nov. 22 2000</b>		3. Time of Death <b>6:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>743 Main Street, P.O. Box 472</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-46-4221</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 7 1947</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>743 Main Street, P.O. Box 472</b>		10f. Zip Code <b>21136</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>n/a</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Employee</b>				16b. Kind of Business/Industry <b>County Recreation</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Lawrence Howard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Hodge</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Loretta Howard/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>743 Main St., P.O. Box 472, Reisterstown, MD 21136</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>Timonium, MD</b>	
	21. Signature of Funeral Service Licensee <b>Lewell M. Lemmon</b>				22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of): <b>b. Lung cancer</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>2 weeks</b> <b>9 months</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>L. Austin Doyle mo</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D23809</b>				29d. Date signed (Month, Day, Year) <b>11/24/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>L. Austin Doyle mo, Greenbaum Cancer Center, 22 S. Greene St., Baltimore, MD 21201</b>				31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>[Signature]</b>				33. Date of Death (Month, Day, Year) <b>11/24/00</b>			
	34. Date of Death (Month, Day, Year) <b>11/24/00</b>				35. Date of Death (Month, Day, Year) <b>11/24/00</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38149

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM L JACKSON</b>		2. Date of Death Month Day Year <b>November 27, 2000</b>		3. Time of Death <b>10:39 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>165-26-5149</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>09-05-35</b>		9. Birthplace (State or Foreign Country) <b>PA</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>2822 Harford Road</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>1 yr.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Stationary Engineer</b>		16b. Kind of Business/Industry <b>Johns Hopkins Hosp</b>
	17. Father's Name (First, Middle, Last) <b>Alexander Jackson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy Mae Jackson</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Veronica Green</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21136 555 Gwynn West Road Reisterstown, Maryland</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crownsville VA Cem.</b>		20c. Location - City or Town, State <b>12-01-2000 Crownsville, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Epidural Abscess</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>5 months</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke, previous deep venous thrombosis</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier  MD		29c. License number <b>D0032548</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>PERRY L COLVIN 10 North Greene Street Baltimore, Maryland</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-0066.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38150

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLE MAE JACKSON				2. Date of Death Month Day Year NOVEMBER 25, 2000		3. Time of Death 12:51 pm	
	4a. Facility Name (If not institution, give street and number) HARTFORD GARDENS				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-82-8387		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 3-6-1916	
	9. Birthplace (State or Foreign Country) GA.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
Usual Residence of Decedent								
10a. State MD.			10b. County N/A			10c. City, Town or Location BALTIMORE		
10e. Street and Number 520 BEAUMONT AVE.			10f. Zip Code 21212			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: BLACK			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -5- College (1-4 or 5+) -0-			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		
16b. Kind of Business/Industry DOMESTIC			17. Father's Name (First, Middle, Last) THOMAS WILLIAMS			18. Mother's Name (First, Middle, Maiden Surname) KATHERINE WILLIAMS		
19a. Informant's Name/Relationship (Type, Print) SYLVIA THOMAS (DAUGHTER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 ST. REGIS RD. BALTIMORE, MARYLAND 21206					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS			20c. Location - City or Town, State 12-1-2000 OWINGS MILLS, MD.		
21. Signature of Funeral Service Licensee Jonathan J. Hixson			22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death less than 2 wks								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Smith			29c. License number D 30661			29d. Date signed (Month, Day, Year) November 23rd 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sireesh TRIPURAWANI 560 Loch Raven Blvd. Baltimore, Md - 21239								
31. Date filed (Month, Day, Year) DEC - 1 2000			32. Registrar's Signature [Signature]					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38151

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Peter Anthony Kucker IV</i>		2. Date of Death Month <i>Nov</i> Day <i>26</i> Year <i>2000</i>		3. Time of Death <i>2247</i>
	4a. Facility Name (If not institution, give street and number) <i>523 Belmawr Place</i>		4b. City, Town, or Location of Death <i>Millersville</i>		4c. County of Death <i>AA</i>
Funeral Director	5. Social Security Number <i>220-08-3660</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>28</i> Yrs.	If Under 1 Year Months <i>0</i> Days <i>0</i>	If Under 24 Hrs. Hours <i>0</i> Min. <i>0</i>
	8. Date of Birth (Month, Day, Year) <i>July 29, 1972</i>		9. Birthplace (State or Foreign Country) <i>New Jersey</i>		
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Millersville</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>1805 Nuthatch Court</i>			10f. Zip Code <i>21108</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Insulator</i>		16b. Kind of Business/Industry <i>Construction</i>
17. Father's Name (First, Middle, Last) <i>Peter Anthony Kucker III</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Leta Lynne Mitchell</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Leta Lynne Longo (Mother)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1805 Nuthatch Court, Millersville, MD 21108</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>Michael P. Kutter</i>		22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death <i>minutes</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
a. <i>Asphyxia</i> Due to (or as a consequence of):					
b. <i>Hanging</i> Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Friend's house</i>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>11/26/00</i>		28b. Time of Injury <i>2200</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Hung self</i>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Home of Friend</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Millersville, MD</i>			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>William P. Jones, MD</i> <i>Deputy</i>		29c. License number <i>D06054</i>		29d. Date signed (Month, Day, Year) <i>11/27/00</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>William P. Jones, MD 695 America 21035</i>					
31. Date filed (Month, Day, Year) <i>DEC - 1 2000</i>		32. Registrar's Signature <i>Benita G. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sophie M. Knapple				2. Date of Death Month Day Year Nov. 27 2000				3. Time of Death 10 :10 PM	
	4a. Facility Name (If not institution, give street and number) Mariner Nursing Home				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-05-7458		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 12, 1900		9. Birthplace (State or Foreign Country) Germany	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10a. Street and Number 633 Plymouth Road				10f. Zip Code 21229		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry sewing		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ludwig Knapple				18. Mother's Name (First, Middle, Maiden Surname) Susanna Brenner					
	19a. Informant's Name/Relationship (Type, Print) Elisabeth Kiarsarsky				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Lee Drive, Catonsville, Maryland 21228					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Date 11/30/2000		20d. Location - City or Town, State Elkridge, Maryland			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Witzke Funeral Home 1630 Edmondson Avenue, Catonsville Maryland 21228					
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GI Bleeding Due to (or as a consequence of): Aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 3 mths	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <i>[Signature]</i> Attending				29c. License number D36942		29d. Date signed (Month, Day, Year) Nov. 29, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. TURAKHIA, MD, 1009 Frederick Rd. Catonsville, MD 21228									
State Registrar	31. Date filed (Month, Day, Year) DEC 1 2000				32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38153

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>RYAN A. KING</u>		2. Date of Death Month <u>November</u> Day <u>28</u> Year <u>2000</u>		3. Time of Death <u>10:18 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>047-84-1395</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>11</u> Yrs.	If Under 1 Year Months <u>  </u> Days <u>  </u>	If Under 24 Hrs. Hours <u>  </u> Min. <u>  </u>
	8. Date of Birth (Month, Day, Year) <u>Mar. 26, 1989</u>		9. Birthplace (State or Foreign Country) <u>Connecticut</u>		
Usual Residence of Decedent					
10a. State <u>Md.</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Glen Arm</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>4309 Conifer Court</u>			10f. Zip Code <u>21057</u>		10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u>		College (1-4 or 5+) <u>  </u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Student</u>	
16b. Kind of Business/Industry <u>Education</u>					
17. Father's Name (First, Middle, Last) <u>Stephen A. King</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Donna J. Smith</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Mrs. Donna J. King/Mother</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4309 Conifer Court Glen Arm, Maryland 21057</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Dulaney Valley Mem. Grd.</u>		20c. Location - City or Town, State <u>Timonium, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Michael J. Rudy</u>		22. Name and Address of Facility <u>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <u>Ventricular Fibrillation</u>					
Due to (or as a consequence of):					
b. <u>Relapsed Leukemia</u>					
Due to (or as a consequence of):					
c. <u>  </u>					
Due to (or as a consequence of):					
d. <u>  </u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>C. Jean Ogborn, MD</u>		29c. License number <u>D39042</u>		29d. Date signed (Month, Day, Year) <u>November 28, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>C. JEAN OGBORN CMSC 144 Johns Hopkins ER</u>					
31. Date filed (Month, Day, Year) <u>DEC 1 2000</u>		32. Registrar's Signature <u>[Signature]</u>			



00-6760-510

KURT LASTER

ASP

amend item 23a,27 per me G791 1/5/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38154

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KURT L. LASTER</b>				2. Date of Death Month Day Year <b>NOVEMBER 28 2000</b>		3. Time of Death <b>7:45 A</b>	
	4e. Facility Name (If not institution, give street and number) <b>827 W. LEXINGTON ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>214-86-8229</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>32 Yrs.</b>		8. Date of Birth Month Day Year <b>JULY 21, 1968</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>827 W. LEXINGTON STREET</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yea or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFRICAN AMERICAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DIETICIAN</b>		16b. Kind of Business/Industry <b>HOSPITAL</b>	
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BETT PLUMMER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>ROBIN LIPSCOMB (SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>827 W. LEXINGTON STREET BALTIMORE, MD 21223</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. Date <b>12/2/00</b>		20d. Location - City or Town, State <b>LANSDOWNE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>WYLIE FUNERAL HOME PA</b> <b>638 N. GILMOR STREET BALTIMORE, MD 21217</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 28, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. Korolev 111 Penn Street, Baltimore, Maryland 21201</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur Leebrick</b>				2. Date of Death Month <b>Nov</b> Day <b>23</b> Year <b>2000</b>		3. Time of Death <b>0615</b>		
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hosp</b>				4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>577-52-3192</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 21, 1938</b>		
	9. Birthplace (State or Foreign Country) <b>unk</b>		10a. State <b>MD</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Morningside</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6702 Marianne Drive</b>		10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>		17. Father's Name (First, Middle, Last) <b>unk</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>	
19a. Informant's Name/Relationship (Type, Print) <b>unk</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b>		20e. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>multiple injuries with complications</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>DME</b>			
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Sep 30, 2000</b>		28b. Time of Injury <b>0904 P.M.</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject was a pedestrian struck by a car</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6700 block of Sullivan Rd. Morningside, Md.</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. N. Baehner M.D. DME</b>		29c. License number <b>D000428</b>		29d. Date signed (Month, Day, Year) <b>Nov 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>IRA N BRECHER, MD DME</b>		31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>G. Sparks</b>		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2101 Medical Park Dr Silver Spring, MD 20902</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38156

amend item 1 per md G790 12/27/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUDOLPH MARBURG</b> Rudolf Marburg				2. Date of Death Month Day Year <b>NOVEMBER 24, 2000</b>		3. Time of Death <b>10:25 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Oakcrest Care Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-34-8165</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 15, 1912</b>		
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8832 Walther Blvd</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (14 or 5+) <b>+5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>physician</b>		16b. Kind of Business/Industry <b>hospital</b>			
17. Father's Name (First, Middle, Last) <b>Otto Marburg</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Stella Becker</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Karen Marburg/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3200 Guilford Ave Baltimore, MD 21218</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LYMPHOMA, Hodgkins type</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death <b>5yrs.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Peripheral vascular disease</b> <b>congestive heart failure</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Daniel Faulles</b>		29c. License number <b>D25643</b>		29d. Date signed (Month, Day, Year) <b>11/27/2000</b>			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>D. Faulles MD/8800 Walther Blvd/Baltimore MD 21234</b>									
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>E. Sparks</b>							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38157

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RONALD J. MATTHEWS</b>				2. Date of Death Month Day Year <b>NOVEMBER 29 2000</b>		3. Time of Death <b>2159</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-44-5516</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>03-11-1946</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5619 Clearspring Road</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Phillip Moore Corp.</b>		16b. Kind of Business/Industry <b>Tractor Tractor Drive</b>		
17. Father's Name (First, Middle, Last) <b>Edgar Matthews</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Matthews</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Matthews-mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5619 Clearspring Rd. Baltimore, MD 21212</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>12-5-2000</b>		20c. Location - City or Town, State <b>Randallstown, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>March Funeral Home, East 1101 E. North Ave., MD 21202</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. PULMONARY EMBOLISM</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 MINUTES</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL DISEASE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 29, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SABRINA TOM JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET, BALTIMORE MD 21287</b>								
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it contains the President's message to the Congress at the beginning of his first term.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It contains a detailed account of the financial state of the United States at the beginning of the year, and a statement of the receipts and expenditures of the Treasury during the year.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It contains a detailed account of the state of the public lands, and a statement of the receipts and expenditures of the Interior Department during the year.

4. The fourth part of the document is a report from the Secretary of the War, dated January 1, 1861. It contains a detailed account of the state of the military, and a statement of the receipts and expenditures of the War Department during the year.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38158

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Shirley Mowery</u>				2. Date of Death Month <u>Nov</u> Day <u>28</u> Year <u>2000</u>		3. Time of Death <u>10:40am</u>	
	4a. Facility Name (If not institution, give street and number) <u>Howard County General Hospital</u>				4b. City, Town, or Location of Death <u>Columbia</u>		4c. County of Death <u>Howard</u>	
Funeral Director	5. Social Security Number <u>219.34.4864</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>64</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Sept. 6, 1936</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>Howard</u>		10c. City, Town or Location <u>Elkridge</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>5626 Furnace Avenue</u>				10f. Zip Code <u>21075</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Factory Worker</u>		16b. Kind of Business/Industry <u>Factory</u>		
17. Father's Name (First, Middle, Last) <u>Albert Decker</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Catherine Cookerly</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Jean Robinson/ Sister</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4318 Leola Avenue Halethorpe, MD 21227</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Gardens of Faith</u>		20c. Location - City or Town, State <u>12/1/00 Baltimore, Maryland</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Gary L. Kaufman Funeral Home at Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, Maryland 21075</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
a. <u>Probable Primary pulmonary hypertension</u> years								
Due to (or as a consequence of):								
b. <u>Chronic Obstructive Pulmonary Disease</u> years								
Due to (or as a consequence of):								
c. <u>Sepsis</u> days								
Due to (or as a consequence of):								
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Carmen Salvaterra M.D.</u>				29c. License number <u>D33627</u>		29d. Date signed (Month, Day, Year) <u>Nov 28, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Carmen Salvaterra M.D. 10724 Little Patuxent Pkwy Columbia, MD 21044</u>								
31. Date filed (Month, Day, Year) <u>DEC - 1 2000</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38159

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DOROTHY E. MOGLE		2. Date of Death Month Day Year NOVEMBER 29, 2000		3. Time of Death 12:05 A.M.	
4a. Facility Name (If not institution, give street and number) 200 KING GEORGE DRIVE		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
5. Social Security Number 212-28-5016	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 17, 1930
9. Birthplace (State or Foreign Country) MARYLAND					
Usual Residence of Decedent					
10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 200 KING GEORGE DRIVE		10f. Zip Code 21061		10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSES AIDE		16b. Kind of Business/Industry HEALTH CARE			
17. Father's Name (First, Middle, Last) NICHOLAS JOHN OBERENDER			18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE HUGHES		
19a. Informant's Name/Relationship (Type, Print) ERIC A. MOGLE / HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 KING GEORGE DRIVE, GLEN BURNIE, MARYLAND 21061			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PARK		20c. Location - City or Town, State GLEN BURNIE, MARYLAND	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  CORONARY ARTERY DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES MELLITUS - type 2,  CONGESTIVE HEART FAILURE,  HYPERTENSION, MULTIPLE CEREBROVASCULAR ACCIDENTS					23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D0021336		29d. Date signed (Month, Day, Year) NOVEMBER 30, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALBIN KUHN, M.D., 8028 RITCHIE HIGHWAY, PASADENA, MARYLAND 21122					
31. Date filed (Month, Day, Year) DEC - 1 2000		32. Registrar's Signature 			

2000 NOV 31 PM 2:43

00 38160

Reg. No.

DHHM 16 Rev 6/95

Leslie Miller



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38161

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Doris A. Myers</b>				2. Date of Death Month <b>November</b> Day <b>25</b> , Year <b>2000</b>				3. Time of Death <b>8:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Augsburg Lutheran Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>213-20-8109 A</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 26, 1925</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5420 Channing Road</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>				16b. Kind of Business/Industry <b>Worker's Compensation Maryland State</b>	
17. Father's Name (First, Middle, Last) <b>Kurtz Myers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mathilda Dreyer</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Thelma DeBoy-Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5112 Westland Boulevard, Baltimore, Maryland 21227</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		Date <b>11-28-00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Lisa S. Jefferson</b>				22. Name and Address of Facility <b>Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. TERMINAL BREAST CANCER</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Approximate Interval Between Onset and Death <b>3 weeks</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Deborah I. Pierce</b>				29c. License number <b>H45931</b>				29d. Date signed (Month, Day, Year) <b>November 27, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Deborah I. Pierce 7220 Park Heights Avenue Baltimore MD</b>									
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>				32. Registrar's Signature <b>Deborah I. Pierce</b>					

State  
Registrar

London Park Cemetery  
London Park Fune.  
3620 Wilkens Ave.

*John D. Apperson*

TERMINAL BREAST CANCER

12231

me k



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38162

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Win Win Mar				2. Date of Death Month Day Year November 30, 2000		3. Time of Death 8:15 A.M.	
	4a. Facility Name (If not institution, give street and number) 10408 Cranbrook Hills Place Apt. G				4b. City, Town, or Location of Death Cockeysville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-35-7273	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	8. Under 1 Year Months Days	9. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 26, 1959		9. Birthplace (State or Foreign Country) Rangoon, Burma
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 10408 Cranbrook Hills Place Apt. G				10f. Zip Code 21030		10g. Citizen of What Country? Burma		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker			16b. Kind of Business/Industry Food Service	
17. Father's Name (First, Middle, Last) Shwe Tun				18. Mother's Name (First, Middle, Maiden Surname) Than Than Tin				
19a. Informant's Name/Relationship (Type, Print) Thit Lwin (husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10408 Cranbrook Hills Place Apt. G, Cockeysville, MD 21030				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gdns			20c. Location - City or Town, State Dec 2 2000 Timonium, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 200 East Padonia Road, Timonium, MD 21093				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic Carcinoma unknown primary 1 year 11 months</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
				29c. License number D18487		29d. Date signed (Month, Day, Year) 11/30/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO TITANT 6830 HOSPITAL DRIVE, BALTO, MD 21237								
31. Date filed (Month, Day, Year) DEC 1 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38163

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Willie E. McKnight</b>				2. Date of Death Month <b>November</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>5:25pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris at Mercy</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>244-12-4255</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Oct. 7, 1923</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1907 Etting St.</b>			10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Track Foreman</b>		16b. Kind of Business/Industry <b>B+O Railroad</b>			
	17. Father's Name (First, Middle, Last) <b>George T. McKnight</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Mitchell</b>			
19a. Informant's Name/Relationship (Type, Print) (Wife) <b>Mrs. Leavonia McKnight</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1907 Etting St. Balto. Md. 21217</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. <b>Pancreatic Cancer</b>								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>hospice</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>D. R. Russ</b>		29c. License number <b>D40654</b>		29d. Date signed (Month, Day, Year) <b>11/28/2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daniel R. Russ 301 St Paul Pl Baltimore 21202</b>								
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38164

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ZOLA MAE NEWBY</b>				2. Date of Death Month <b>NOV.</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>11:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOSEPH RICHIE HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220 14 2962</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 6, 1927</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>812 Mount Holly Street</b>		10f. Zip Code <b>21229</b>	
	10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
	17. Father's Name (First, Middle, Last) <b>FORREST PETTY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ZOLA MAE GUILICK</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MELVIN NEWBY / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2845 BANEGRARY GURT BALTIMORE, Maryland 21209</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL CEMETERY</b>		20c. Location - City or Town, State <b>BALTIMORE, Maryland</b>		20d. Date <b>11/6/2000</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CHARTMAN - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21141</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cerebrovascular event</b> Due to (or as a consequence of): b. <b>Multiple infarct dementia</b> Due to (or as a consequence of): c. <b>hypertension</b> Due to (or as a consequence of): d. <b>Congestive heart failure</b>  Approximate Interval Between Onset and Death a. <b>2 months</b> b. <b>2 months</b> c. <b>unknown</b> d. <b>unknown</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>urosepsis</b> <b>pneumonia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of injury <b>N/A</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>N/A</b>				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Brent B. Macdonald, M.D.</b>		29c. License number <b>D47105</b>		29d. Date signed (Month, Day, Year) <b>11/21/00</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Brent B. Macdonald, M.D. 2400 KIRK Avenue, Balt, MD 21218</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 30 2000</b>		32. Registrar's Signature 					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38165

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Winifred B. O'Brien		2. Date of Death Month Day Year NOV 30 2000		3. Time of Death 11:10 AM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 214-30-6412	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 4, 1933
	9. Birthplace (State or Foreign Country) Baltimore					
Usual Residence of Decedent						
10a. State MD		10b. County Baltimore		10c. City, Town or Location Halethorpe		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 4518-A-Spring Ave.		10f. Zip Code 21227		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16. Kind of Business/Industry Private Contractor		
17. Father's Name (First, Middle, Last) John P. McGowan		18. Mother's Name (First, Middle, Maiden Surname) Margaret Horan				
19a. Informant's Name/Relationship (Type, Print) Sheila Kurth-Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4518-A-Spring Avenue, Halethorpe, Maryland 21227				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State Date 12/06/2000 Baltimore, Maryland		
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
Immediate Cause (Final disease or condition resulting in death)		a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of):				Approximate Interval Between Onset and Death 4 Days
		b. <u>LUNG CANCER</u> Due to (or as a consequence of):				4 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. _____ Due to (or as a consequence of):				
		d. _____ Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u>						
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier [Signature]		29c. License number P-13592		29d. Date signed (Month, Day, Year) NOV 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEXANDER J. THORSON, 900 CATON AVE. BALTIMORE 21229						
31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature [Signature]				

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME O'BRIEN, WINIFRED B.  
Division of Vital Records, P.O. Box 68760,

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38166

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Purnell

2. Date of Death

November

Day

28

Year

00

3. Time of Death

738 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

218-46-6079

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
December 23, 42

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4602 Waterfall Ct.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

Bacto. City Schools

17. Father's Name (First, Middle, Last)

Percy Nicholson Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Drummond

19a. Informant's Name/Relationship (Type, Print)

Bennie Purnell - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4602 Waterfall Ct. Owings Mills Md 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park 12/4/00 Randallstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March Funeral Home West, Inc  
4300 Wabash Ave. Balt. Md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Respiratory Failure

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 4333

29d. Date signed (Month, Day, Year)

November, 28, 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lyle Campbell MD. Northwest Hospital

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MARGARET  
PERRY

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38167

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret E. Perry</b>		2. Date of Death Month Day Year <b>NOVEMBER 25, 2000</b>		3. Time of Death <b>8:25P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>234 N. MONROE STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>193-78-0553</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>02 23 32</b>		9. Birthplace (State or Foreign Country) <b>P.A.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>NA</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>234 North Monroe Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (14 or 5+) <b>na</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laundry Worker</b>		16b. Kind of Business/Industry <b>Hospital</b>		
	17. Father's Name (First, Middle, Last) <b>Henry Sturoliant</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Cromartie</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Eric V. Adams-Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4804 Loch Raven Blvd, Baltimore Md 21239</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>12/2/00 Arbutus, Md</b>
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b>				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <b>INSPECTION</b>				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>J. Pustan, M.D.</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 26, 2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSEPH PESTANER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>				
	31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800.688.8000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Edwin Perkins  
amend item 23a,b,27 per me G791 1/9/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 38168  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edwin Perkins</b>					2. Date of Death Month Day Year <b>November 28 2000</b>			3. Time of Death <b>07:50 A.M.</b>		
	4a. Facility Name (If not Institution, give street and number) <b>2137 West Lexington Street</b>					4b. City, Town, or Location of Death <b>Baltimore</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218-62-9230</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02 01 54</b>		9. Birthplace (State or Foreign Country) <b>M.D.</b>			
	Usual Residence of Decedent										
10a. State <b>MD</b>			10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2137 West Lexington Street</b>					10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security/Special Police</b>			16b. Kind of Business/Industry <b>Mercy Hospital</b>			
17. Father's Name (First, Middle, Last) <b>Edward Perkins</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Isabelle Jones</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Isabelle Perkins-Mother</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2137 West Lexington St. Baltimore Md 21223</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD National Park</b>			20c. Date <b>12/4/00</b>		20d. Location - City or Town, State <b>Laurel, Md</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>March F/H West 4300 Wabash Ave, Baltimore Md 21215</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>SEPSIS</b> Due to (or as a consequence of):  b. <b>HEPATIC ABSCESS</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 28, 2000</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38169

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine M. Plack</b>				2. Date of Death Month Day Year <b>Nov. 29 2000</b>				3. Time of Death <b>4:20 A.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Mariner Health of North Arundel</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>214-22-8621</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 8, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1005 Cutler Harbor</b>				10f. Zip Code <b>21122</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>				17. Father's Name (First, Middle, Last) <b>Richard T. Jones</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Imbach</b>				19a. Informant's Name/Relationship (Type, Print) <b>Catherine M. Dailey (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Cutler Harbor Pasadena, Maryland 21122</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park</b>				20c. Location - City or Town, State <b>12/2/00 Woodlawn Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of): hours	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D-40521</b>	
	29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. OCHANEY</b>				31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>	
	32. Registrar's Signature 				33. Date of Death <b>3350 Wilkens Avenue Suite 302 Baltimore, MD 21229</b>				34. State Registrar <b>DEC - 1 2000</b>	

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38170

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Lee Purdham, Sr.

2. Date of Death  
Month Day Year  
November 27, 2000

3. Time of Death  
7:55pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital Glen Burnie Anne Arundel

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

219-28-0685

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 21, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1264 Sleepy Hollow Road

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Glass Company

17. Father's Name (First, Middle, Last)

Christopher S. Purdham

18. Mother's Name (First, Middle, Maiden Summa)

Hazel Knight

19a. Informant's Name/Relationship (Type, Print)

Mary M. Purdham (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1264 Sleepy Hollow Road, Severn, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

12/01  
2000

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Michael D. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Hepatic Failure

Due to (or as a consequence of):

b. Congestive Heart Failure (advanced)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema, Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D51245

29d. Date signed (Month, Day, Year)

November 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SASID SHARIF North Arundel Hospital - Glen Burnie, MD

State  
Registrar

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

ORIGINAL

Purdham  
Baltimore, Maryland 21215-0020

James  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38171

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUE ELIZABETH PETERS

2. Date of Death  
Month Day Year  
NOVEMBER 25, 20003. Time of Death  
1:00 A.M.

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

213-30-6614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Mar 18, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1728 Trotting Court

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

grocer

16b. Kind of Business/Industry

self employed

17. Father's Name (First, Middle, Last)

Robert Beamer

18. Mother's Name (First, Middle, Maiden Surname)

Dollie Peters

19a. Informant's Name/Relationship (Type, Print)

Kathryn Thompson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1728 Trotting Court Jarrettsville, MD 21084

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. end stage coronary artery disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt; 7 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerosis

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

D32279

29d. Date signed (Month, Day, Year)

November 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 215 W. Maryland

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38172

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>WILLIE JOSEPH POSEY, JR.</i>		2. Date of Death Month Day Year <i>November 25 2000</i>		3. Time of Death <i>2:29 A.M.</i>			
4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>			
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>30</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct 9, 1970</i>		
9. Birthplace (State or Foreign Country) <i>Maryland</i>		10. Usual Residence of Decedent					
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>6510 PARK HEIGHTS AVE</i>		10f. Zip Code <i>21215</i>			
10g. Citizen of What Country? <i>USA</i>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Packer</i>		16b. Kind of Business/Industry <i>SWEET HEART Cup Company</i>		17. Father's Name (First, Middle, Last) <i>Willie J. Posey, Sr.</i>			
18. Mother's Name (First, Middle, Maiden Surname) <i>Florence Carter</i>		19a. Informant's Name/Relationship (Type, Print) <i>Florence Harvey / Mother</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6510 PARK HEIGHTS AVE Baltimore, Md 21215</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT Zion Cemetery</i>		20c. Date <i>11-30-2000</i>			
20d. Location - City or Town, State <i>Baltimore, Maryland</i>		21. Signature of Funeral Service Licensee <i>James Harris</i>		22. Name and Address of Facility <i>CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Multiple Injuries</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i>11/25/00</i>		28b. Time of Injury <i>0157 AM</i>			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Pedestrian Struck by Vehicle</i>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <i>Baltimore, Maryland</i>			
28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Street</i>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>J. Pestaner, M.D.</i>		29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>November 25, 2000</i>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</i>							
31. Date filed (Month, Day, Year) <i>NOV 30 2000</i>		32. Registrar's Signature <i>James Harris</i>					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Webb Parks, Sr.				2. Date of Death Month Day Year NOV 29 2000				3. Time of Death 1355		
	4a. Facility Name (If not institution, give street and number) ST AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-16-3310		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 78		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Sept. 1, 1922		
	Usual Residence of Decedent		10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5402 Gwynndale Avenue		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Year or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Myerberg Construction		17. Father's Name (First, Middle, Last) Powell Parks		18. Mother's Name (First, Middle, Maiden Surname) Mary M. Webb	
19a. Informant's Name/Relationship (Type, Print) Jean K. Parks (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5402 Gwynndale Avenue; Woodlawn, Maryland 21207		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Date 12/4/00		20d. Location - City or Town, State Woodlawn, Maryland	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line. e. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Shirin Ahmad		29c. License number P14438		29d. Date signed (Month, Day, Year) NOV, 29, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIRIN AHMAD 900 CATON AVE		31. Date filed (Month, Day, Year) DEC - 1 2000	
32. Registrar's Signature		33. State Registrar		34. State Registrar		35. State Registrar		36. State Registrar		37. State Registrar	

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38174

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WILLIAM PROCTOR SR.

2. Date of Death

Month Day Year  
November 26 2000

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH CENTER

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

248-48-0890

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-24-1931

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4040 BOARMAN AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

-8-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CHEF

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

HOLLIE PROCTOR

18. Mother's Name (First, Middle, Maiden Surname)

MARY MARION

19a. Informant's Name/Relationship (Type, Print)

DAISY DIGGS (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4040 BOARMAN AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

11-30-2000 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Jonathan O. Hise*

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.  
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Jonathan O. Hise MD*

29c. License number

DIS872

29d. Date signed (Month, Day, Year)

Nov 29 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HAROLD BUB 25 Main St Reisterstown MD 21136

31. Date filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

*Beverly B. Sparks*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED ITEM# 23a per ME G792 030101 SS

80 38175

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Virgil Rosber, Jr.</b>		2. Date of Death Month <b>November</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>11:20 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>717 Druid Park Lake Drive # 1106</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>216-30-6739</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>12-16-31</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>717 Druid Park Lake Drive</b>		10f. Zip Code <b>21217</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Contractor Co.</b>	
17. Father's Name (First, Middle, Last) <b>Virgil W. Rosber, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jane Gaither</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Diana L. Rosber</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 Mosander Way Baltimore, Maryland 21224</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>Lansdowne, MD</b>	
21. Signature of Funeral Service Licensee <b>Gladys Wane</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>			

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND KETOACIDOSIS</b>		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>			
Due to (or as a consequence of):			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <b>Yes</b>		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11/27/2000</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Wayne M. Kule</b>	
29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 28, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne M. Kule</b>		31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>	
32. Registrar's Signature <b>Wayne M. Kule</b>		33. Registrar's Name <b>Wayne M. Kule</b>	

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2003 NOV 31 PM 2:51

00-6773-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JAMES

State of Maryland / Department of Health and Mental Hygiene

RATHER amend item 23a,b, 27 per me G790 12/7/00 yf **Certificate of Death**

Reg. No.

00 38176

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James E. Rather</b>						2. Date of Death Month Day Year <b>NOVEMBER 28, 2000</b>		3. Time of Death <b>3:30 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>5408 RADECKE AVE</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>215-60-6834</b>		6. Sex <b>XXM</b> 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01-21-54</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>5408 Radecke Avenue</b>						10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fulltime</b>			16b. Kind of Business/Industry <b>Army</b>				
17. Father's Name (First, Middle, Last) <b>Oscar Rather</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Fowlkes</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Lillian M. Epps Courts</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5408 Radecke Avenue Baltimore, MD 21206</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem.</b>		20c. Location - City or Town, State <b>MD</b>		20d. Date <b>12-05-2000</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEIZURE DISORDER</b> Due to (or as a consequence of): <b>b. CHRONIC ALCOHOLISM</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and Title of certifier 						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 29, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chutano</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





00-6751-510  
00-329  
Jennie Rutkowski

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JENNIE C. RUTKOWSKI</b>				2. Date of Death Month Day Year <b>NOVEMBER 27, 2000</b>		3. Time of Death <b>5:00P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>3501 7th STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>217-76-9275</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 29 1965</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>1841 S. Charles Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Resturant</b>		
17. Father's Name (First, Middle, Last) <b>John J. Rutkowski</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>Beatrice Orwig</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Beatrice Rutkowski (Mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6718 Gary Ave. Baltimore, Md. 21222</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>12/01/2000</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multiple Stab Wounds</b>								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Stab Wounds</b> Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>11/27/00 (Found)</b>		28b. Time of Injury <b>4:30 PM (Found)</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Stabbed</b>
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Warehouse</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Baltimore, Md.</b>				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 28, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38178

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kacheshwar Rajguru</b>						2. Date of Death Month Day Year <b>November 26, 2000</b>		3. Time of Death <b>10:45 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>2633 Antler Court</b>						4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>218-21-1689</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 6, 1908</b>		9. Birthplace (State or Foreign Country) <b>India</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2633 Antler Court</b>				10f. Zip Code <b>20904</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lawyer</b>			16b. Kind of Business/Industry <b>Legal</b>			
17. Father's Name (First, Middle, Last) <b>Shankark Rajguru</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>G. Sudum</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Umakant Rajguru/Son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2633 Antler Court, Silver Spring, Maryland 20904</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington Cr.</b>		Date <b>12/1/00</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Aortic Stenosis</b> Due to (or as a consequence of): b. <b>Pulmonary Edema</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										<b>years,</b> <b>months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Kacheshwar, MD</b>		29c. License number <b>D20108</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAKESH AROPA, MD 14300 GALLANT FOX LN, BOWIE, MD 20715</b>										
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>		32. Registrar's Signature 								

ORIGINAL

200 NOV 31 2111:09

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38179

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD JOSEPH RUSAK</b>				2. Date of Death Month <b>November</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>1810</b>	
	4a. Facility Name (If not institution, give street and number) <b>BETHESDA HOUSE - 4848 CORNELL AVENUE</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>215-70-1576</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 28, 1955</b>	9. Birthplace (State or Foreign Country) <b>unk</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>4848 Cornell Avenue</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>unk</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> Collega (1-4or 5+) <b>unk</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>			
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>unk</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>unk</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>in state</b>		Data		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ANTERIOSCROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>EPHEDRINE</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Street</b>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>no. (one)</b>				29c. License number <b>015236</b>		29d. Date signed (Month, Day, Year) <b>November 26, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CARL J. MARGOLIS, MD, 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>							
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>				32. Registrar's Signature <b>B. Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38180

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EUGENE RICHARDSON

2. Date of Death  
MonthDay Year  
NOVEMBER 13<sup>TH</sup>, 2000

3. Time of Death

10:58 PM

4a. Facility Name (If not institution, give street and number)

RAVENWOOD NURSING &amp; REHAB CTR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N-A

Funeral  
Director

5. Social Security Number

218-05-1376

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

1-11-1907

9. Birthplace (State or Foreign  
Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1107 CREEK ST.

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☐ Yes ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-8-

College (1-4or 5+)

-0-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

BAKER

16b. Kind of Business/Industry

BAKERY

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

EDWARD RICHARDSON(SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

704 S. BEECHFIELD AVE. BALTIMORE, MARYLAND 21229

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

11-24-2000 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hines

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.  
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Approximate  
Interval Between  
Onset and Death

YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending  
Investigation☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vasanthakumari

29c. License number

D42510

29d. Date signed (Month, Day, Year)

Nov. 25<sup>TH</sup>, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.V. KUMAR, 821 N. EUTAW ST SUITE 407, MD 21201.

State  
Registrar

31. Data filed (Month, Day, Year)

DEC - 1 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



00-6813-510

THORNELL STOKES

JVW amend item 23a,b,27,28a,b,c,d,ef, per me G790 12/6/00 **Certificate of Death**

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

00 38181

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THORNELL ALBERT STOKES

2. Date of Death  
Month Day Year  
NOVEMBER 30, 20003. Time of Death  
02:25 A.M.

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

219-52-9911

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 4, 1951

9. Birthplace (State or Foreign Country)

CREW, VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1503 MEDFORD RD

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRICAN

Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SANITATION

16b. Kind of Business/Industry

BALTIMORE CITY

17. Father's Name (First, Middle, Last)

ALBERT STOKES

18. Mother's Name (First, Middle, Maiden Surname)

LEOLA H. STOKES

19a. Informant's Name/Relationship (Type, Print)

DORIS STOKES (STEP-MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3604 KENYON AVENUE BALTIMORE, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VET. CEM. 12/6/00 OWINGS MILLS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE IN ASSOCIATION WITH NARCOTIC INTOXICATION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

found: 11/30/00

28b. Time of Injury

found: 1:45

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

outside store

28f. Location (Street and Number or Rural Route Number, City or Town, State)

100 S. Broadway St., Baltimore, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 1 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 11 PER F.H. G790 12-4-00 WR.

State of Maryland / Department of Health and Mental Hygiene

00 38182

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>VERNA SANDRY</i>				2. Date of Death Month <i>Nov.</i> Day <i>30</i> Year <i>2000</i>			3. Time of Death <i>6:45 AM</i>		
	4e. Facility Name (If not institution, give street and number) <i>St. Agnes Health Care</i>				4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>287-16-8997</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>77</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>DEC. 10, 1922</i>		9. Birthplace (State or Foreign Country) <i>Ohio</i>	
	Usual Residence of Decedent				10f. Zip Code <i>20794</i>		10g. Citizen of What Country? <i>USA</i>			
10a. State <i>MD</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Jessup</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>7206 Montevideo Road</i>				10f. Zip Code <i>20794</i>				10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>white</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Own Home</i>		
17. Father's Name (First, Middle, Last) <i>Earl Dupper</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Nora Meek</i>						
19a. Informant's Name/Relationship (Type, Print) <i>John Sandry - husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7206 Montevideo Road, Jessup, Md. 20794</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadowridge Memorial Park</i>				20c. Location - City or Town, State <i>Elkridge, Md.</i>		
21. Signature of Funeral Service Licensee <i>Mark Marshall</i>				22. Name and Address of Facility <i>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <i>Sepsis</i> <i>Pneumonia</i>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Leila Kump, M.D.</i>				29c. License number <i>P 14444</i>		
29d. Date signed (Month, Day, Year) <i>Nov. 30, 2000</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>LEILA KUMP 900 Caton Ave, BALTIMORE, MD 21229</i>						
31. Date filed (Month, Day, Year) <i>DEC - 1 2000</i>				32. Registrar's Signature <i>B Sparks</i>						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38183

AMEND ITEM: 21 PER D.V.R. 790 12-11-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll Robert Senner				2. Date of Death Month Day Year NOVEMBER 23, 2000		3. Time of Death 1:40 A.M.
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 214-26-5459	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 26, 1929	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent						
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 4215 Bayonne Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cabinet maker		16b. Kind of Business/Industry Furniture	
17. Father's Name (First, Middle, Last) Carroll R. Senner				18. Mother's Name (First, Middle, Maiden Surname) Helen Miller			
19a. Informant's Name/Relationship (Type, Print) Shirley Reid-sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12111 Tullamore Ct. Unit 303, Timonium, MD 21093			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery		Date 11/27/00		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee MICHAEL E. CANAPP				22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR TACHYCARDIA Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCT Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. ATHEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate interval Between Onset and Death 3 HOURS 3 HOURS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FAILED PACEMAKER FUNCTION SEVERE ANEMIA							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier [Signature] MD		29c. License number D42083		29d. Date signed (Month, Day, Year) NOVEMBER 23, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUNTA A. WHEELER, MD GOOD SAMARITAN HOSPITAL							
31. Date filed (Month, Day, Year) NOV 28 2000				32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38184

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pearl A. Stowers</b>						2. Date of Death Month Day Year <b>November 21, 2000</b>			3. Time of Death <b>1305 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Lorien Nursing Home</b>						4b. City, Town, or Location of Death <b>Columbia</b>			4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>577-18-8247</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 23, 1918</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Clarksville</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>5687 Chandoly Drive</b>				10f. Zip Code <b>21029</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Billing Clerk</b>			16b. Kind of Business/Industry <b>Wholesaler</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Pitrone</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Sophie (Fera)</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Wilson-daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5687 Chandoly Drive, Clarksville, Maryland 21029</b>				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore/Washington Crem.</b>		20c. Date <b>11/27/2000</b>		20d. Location - City or Town, State <b>Laurel, Maryland</b>				
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Rheumatoid Arthritis</b> Due to (or as a consequence of): b. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>										
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier <i>[Signature]</i>						29c. License number <b>D3557J</b>		29d. Date signed (Month, Day, Year) <b>November 23, 2000</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KODOLU ESTZ #202 9501 Old Annapolis Rd Ellicott City MD 21042</b>										
	31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38185

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nora S. Slick</b>				2. Date of Death Month <b>November</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>6:15 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Copper Ridge Nursing Home</b>				4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>217-12-2441</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 20, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>12658 Golden Oak Drive</b>		10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Chemical</b>			
	17. Father's Name (First, Middle, Last) <b>Oliver Baker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Davis</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Jacquelyn White- Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12658 Golden Oak Drive, Ellicott City, Maryland</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Location - City or Town, State <b>November 29, 2000 Frederick, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Kirk Schlenger</b>				22. Name and Address of Facility <b>Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228</b>			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Adenocarcinoma of the colon</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>Ernestine Wright</b>				29c. License number <b>D5 2740</b>		29d. Date signed (Month, Day, Year) <b>November 27<sup>th</sup>, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ernestine Wnght, Copper Ridge, Sykesville MD 21784</b>							
31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>				32. Registrar's Signature <b>B. Sparks</b>				

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38186

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Inda Sheyner</b>				2. Date of Death Month Day Year <b>November 28 2000</b>		3. Time of Death <b>12:07</b>														
	4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>														
Funeral Director	5. Social Security Number <b>216-43-7054</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP. 20, 1923</b>														
	9. Birthplace (State or Foreign Country) <b>UKRAINE</b>																				
Usual Residence of Decedent																					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>REISTERSTOWN</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
10e. Street and Number <b>5 SHROPSHIRE COURT</b>				10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>UKRAINE</b>															
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>															
17. Father's Name (First, Middle, Last) <b>DAVID LANTSMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BETTIE TUCHINSKY</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>MIKHAIL SHEYNER / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 SHROPSHIRE COURT - REISTERSTOWN, MD 21136</b>																	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEMETERY 11/30/00 REISTERSTOWN, MD</b>		20c. Location - City or Town, State															
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Acute peritonitis</b></td> <td>days</td> </tr> <tr> <td>b.</td> <td><b>Bowel obstruction</b></td> <td>days</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Acute peritonitis</b>	days	b.	<b>Bowel obstruction</b>	days	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Acute peritonitis</b>	days																		
	b.	<b>Bowel obstruction</b>	days																		
	c.																				
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure, renal insufficiency</b>																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D43453</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>V. DIXON KING, JR., MD NORTHWEST HOSPITAL CENTER</b>																					
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>				32. Registrar's Signature <i>[Signature]</i>																	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified in accordance with the law.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



STiles, Annice

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38187

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annice Duncan Stiles				2. Date of Death Month: November Day: 29, Year: 2000		3. Time of Death 9:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Dulaney Towson Nursing Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 217-62-4370	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2-20-1909		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 111 West Road				10f. Zip Code 21204		10g. Citizen of What Country? U. S. A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Kernan Hospital	
17. Father's Name (First, Middle, Last) Hugh Robert Duncan				18. Mother's Name (First, Middle, Maiden Surname) Dora Willetta Duncan				
19a. Informant's Name/Relationship (Type, Print) Mrs Martha S. Poehler (Dtr.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Smeton Place, Towson, Maryland 21204				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 12-1-00		20c. Location - City or Town, State Towson, Maryland
21. Signature of Funeral Service Licensee Wallace S. Brack, Jr.				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death one week
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Attending MD		29c. License number 037016		29d. Date signed (Month, Day, Year) November 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth M. Green, MD 6701 N. Charles H., Suite 4105 Yorktown, MD 21204								
State Registrar	31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature James B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38188

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Sara C. Schlesinger</u>				2. Date of Death Month <u>October</u> Day <u>1</u> Year <u>2000</u>		3. Time of Death <u>5:50PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Northwest Hospital Center</u>				4b. City, Town, or Location of Death <u>Randallstown</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>213-20-8091</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>90</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>JAN.18,1910</u>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <u>MD</u>		10a. State <u>MD</u>		10b. County <u>N/A</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>BALTIMORE</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <u>2907 FALLSTAFF ROAD #15</u>	
	10f. Zip Code <u>21209</u>				10g. Citizen of What Country? <u>U.S.A.</u>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>HOUSEWIFE</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEWIFE</u>		16b. Kind of Business/Industry <u>OWN HOME</u>	
	17. Father's Name (First, Middle, Last) <u>DAVID COHEN</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>ROCHELLE MARCOLESCEAU</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>RICHARD SHOFR / SON</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>216 ST. DUNSTANS ROAD - BALTIMORE, MD 21212</u>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>BALTIMORE HEBREW CEMETERY</u>		20c. Location - City or Town, State <u>10/4/00 BALTIMORE, MD</u>	
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>SOL LEVINSON &amp; BROS., INC.</u> <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Anterior myocardial infarction</u> Due to (or as a consequence of): b. <u>Coronary artery disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebrovascular disease</u> <u>Hypertension</u> <u>Peripheral vascular disease</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <u>M</u>		28b. Time of Injury <u>1</u> <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D28462</u>		
29d. Date signed (Month, Day, Year) <u>October 1, 2000</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>J Boston Northwest Hospital 5401 Old Court Road Randallstown, Maryland</u>				
31. Date filed (Month, Day, Year) <u>OCT 05 2000</u>				32. Registrar's Signature <u>[Signature]</u>				

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38189

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Leroy Smith</b>				2. Date of Death Month <b>November</b> Day <b>23</b> Year <b>2000</b>		3. Time of Death <b>9<sup>00</sup> AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Richey Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>267-31-2132</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year <b>March 2, 1963</b>		9. Birthplace (State or Foreign Country) <b>Florida</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>915 Abbott Court</b>				10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unemployed</b>		16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>James W. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Willie Mae Edwards</b>				
19a. Informant's Name/Relationship (Type, Print) (Brother) <b>Mr. Charles E. Smith</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4127 Balmoral Circle Balto. Md. 21208</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		20d. Date <b>12/5/2000</b>		
21. Signature of Funeral Service licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>AIDS</b> Due to (or as a consequence of):  <b>72 yrs</b>								Approximate Interval Between Onset and Death
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Kaposi Sarcoma</b>								23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): <b>Hospice</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>John T. Payne, MD</b>		29c. License number <b>D13012</b>		29d. Date signed (Month, Day, Year) <b>24 NOV 00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2565 N. Chomley St. Baltimore, Md 21204</b>								
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38190

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Monique Simms</b>				2. Date of Death Month <b>November</b> Day <b>24</b> , Year <b>2000</b>		3. Time of Death <b>06:10pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-72-7306</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>Sept. 9, 1964</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5927 Daywalt Ave.</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Clerk</b>		16b. Kind of Business/Industry <b>General Dollar Store</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Anthony Powell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clorie Mae Johnson</b>			
	19a. Informant's Name/Relationship (Type, Print) (Husband) <b>Mr. Dan Simms</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1310 Chapel Hill Drive, Balto, Md. 21237</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Location - City or Town, State <b>12/5/2000 Owings Mills, Md.</b>		20d. Date	
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Superior sagittal venous thrombosis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>2 days</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Schizophrenia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <b>Dr. Myechia Minter</b>				29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>November 24, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Myechia Minter Sinai Hospital</b>							
	31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature <b>Sparks</b>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38191

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Ellen Tucker				2. Date of Death Month Day Year November 27 2000		3. Time of Death 0558	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number N/A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days		8. Date of Birth (Month, Day, Year) Nov. 26, 2000	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1129 Hampton Road		10f. Zip Code 21401		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		17. Father's Name (First, Middle, Last) Walter Lawrence Tucker, III	
	18. Mother's Name (First, Middle, Maiden Surname) Gail Rebecca Eisenhower		19a. Informant's Name/Relationship (Type, Print) Walter L. Tucker, III (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Hampton Road, Annapolis, MD 21401		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Baltimore, MD		21. Signature of Funeral Service Licensee Michael P. Kotta		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Persistent Pulmonary Hypertension of Newborn 13 hours Due to (or as a consequence of): b. Pulmonary Hypoplasia 13 hours Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Yann Lin, MD		29c. License number D047158		29d. Date signed (Month, Day, Year) November 27, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yann Lin, MD Anne Arundel Medical Center Jennifer Rd, Annapolis, MD 21401		31. Date filed (Month, Day, Year)		32. Registrar's Signature		33. State Registrar	





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38192

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edwin Testa						2. Date of Death Month Day Year November 27 2000		3. Time of Death 11:00 PM	
	4a. Facility Name (If not institution, give street and number) 7589 Shields Drive						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 186-36-2189		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 17, 1946		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10e. State MD		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7589 Shields Drive						10f. Zip Code 21705		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1965 1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self employed				16b. Kind of Business/Industry Contractor		
17. Father's Name (First, Middle, Last) James Testa						18. Mother's Name (First, Middle, Maiden Surname) Anna Callahan				
19a. Informant's Name/Relationship (Type, Print) Elizabeth Testa- Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7589 Shields Drive, Frederick, Maryland 21705				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion Cemetery		Date 11/30/2000		20c. Location - City or Town, State Collingdale, Pennsylvania		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Heart failure - Hypotension Due to (or as a consequence of): b. small cell cancer of lung & metastasis Due to (or as a consequence of): c. Renal failure 2 <sup>nd</sup> to metastasis Due to (or as a consequence of): d. cord compression, neurogenic bladder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cachexia 2 <sup>nd</sup> to cancerous process. muscle wasting. Hospice pt on Narcotic drugs.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier S. Mohindian MD.				29c. License number D39458		29d. Date signed (Month, Day, Year) 11-28-00.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEBEBA MOHIDIAN 801 TOLL HOUSE AVE. FREDERICK, MD. 21701- BLDG "B" SUITE 1										
31. Date filed (Month, Day, Year) DEC 1 2000				32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38193

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES Thompson</b>				2. Date of Death Month <b>11</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>6:15 PM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Alice Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>252-30-2671</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12 27 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Georgia</b>		10e. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10e. State		10b. County		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2095 Rockrose Avenue</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>unk</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>owner</b>		16b. Kind of Business/Industry <b>furniture store</b>		
17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Paul Martell/foster son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic prostate carcinoma</b> Due to (or as a consequence of): <b>b. status post bilateral orchiectomy</b> Due to (or as a consequence of): <b>c. Dementia</b> Due to (or as a consequence of): <b>d. Anemia</b>				Approximate Interval Between Onset and Death				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Protein calorie malnutrition</b> <b>Degenerative Joint Disease</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Protein calorie malnutrition</b> <b>Degenerative Joint Disease</b>				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Protein calorie malnutrition</b> <b>Degenerative Joint Disease</b>				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D31464</b>				
29b. Signature and title of certifier <b>Pattar MD.</b>				29d. Date signed (Month, Day, Year) <b>11/28/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHOAH A. HASHMI 821 N. EUTAW ST, Suite 308, Baltimore MD 21201</b>				31. Date filed (Month, Day, Year) <b>DEC 1 2000</b>				
32. Registrar's Signature <b>B. Sparks</b>								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38194

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mark J Trenner				2. Date of Death Month Day Year November 28 2000				3. Time of Death 08:43 A.M.			
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A			
Funeral Director	5. Social Security Number 219-56-4125		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) June 6, 1955		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10e. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 1 Kittredge Lane				10f. Zip Code 21204-3524		10g. Citizen of What Country? United States					
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millwright				16b. Kind of Business/Industry Steel Industry			
	17. Father's Name (First, Middle, Last) Jack F. Trenner				18. Mother's Name (First, Middle, Maiden Surname) Gloria M. Peters							
	19a. Informant's Name/Relationship (Type, Print) Mr. Jack F. Trenner / father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Kittredge Lane Baltimore, Maryland 21204							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Date 11/30/00		20d. Location - City or Town, State Towson, Maryland					
	21. Signature of Funeral Service Licensee  Stephen D. Coster				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>OCCLUSIVE PULMONARY THROMBOEMBOLY</u> Due to (or as a consequence of): b. <u>DEEP LEG VEIN THROMBOSIS</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>OBESITY</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier  M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 29, 2000					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary G. Ripple, 111 Penn Street, Baltimore, Maryland 21201											
	31. Date filed (Month, Day, Year) DEC 1 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38195

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY L. WILSON				2. Date of Death Month Day Year NOV. 23, 2000				3. Time of Death 2015		
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 415-56-3743		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) March 8, 1934		9. Birthplace (State or Foreign Country) Tennessee		
	Usual Residence of Decedent										
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crownsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 911 Coulson Road				10f. Zip Code 21032				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper				16b. Kind of Business/Industry Nursing Care			
17. Father's Name (First, Middle, Last) Walter Long				18. Mother's Name (First, Middle, Maiden Surname) Nancy Unknown							
19a. Informant's Name/Relationship (Type, Print) Charles F. Wilson, Jr. (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Coulson Road, Crownsville, MD 21032							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.		Date 11/29 2000		20c. Location - City or Town, State Crownsville, MD					
21. Signature of Funeral Service Licensee <i>Betty Wilson</i>				22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>congestive heart failure</i> Due to (or as a consequence of): b. <i>ischemic cardiomyopathy</i> Due to (or as a consequence of): c. <i>coronary artery disease</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4/15 4/15 4/15	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension emphysema</i>										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Gregory A. Mitchell, MD</i>				29c. License number D14758				29d. Date signed (Month, Day, Year) 11-25-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory A. Mitchell, MD 621 Ridgely Avenue, Annapolis, MD 21401											
State Registrar		31. Date filed (Month, Day, Year) DEC - 1 2000		32. Registrar's Signature <i>James B. Spauls</i>							

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed immediately after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38196

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Milan Vanko</i>				2. Date of Death Month <i>November</i> Day <i>29</i> Year <i>2000</i>				3. Time of Death <i>7:22 p.m.</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death		
Funeral Director	5. Social Security Number <i>230-22-5140</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>72</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>June 19, 1928</i>		9. Birthplace (State or Foreign Country) <i>Virginia</i>		
	Usual Residence of Decedent				10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <i>1538 Barrett Road</i>				10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Electrician</i>				16b. Kind of Business/Industry <i>General Motors</i>			
17. Father's Name (First, Middle, Last) <i>John Vanko, Jr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Urbanchok</i>							
19a. Informant's Name/Relationship (Type, Print) <i>Lori Ann Vanko Koch-daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1728 Hall Ave, Arbutus, Maryland 21227</i>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Buck Valley Memorial Cem.</i>				20c. Location - City or Town, State <i>Pennsylvania</i>		20d. Date <i>12/04/2000</i>	
21. Signature of Funeral Service Licensee <i>Kirk Schlenger MD</i>				22. Name and Address of Facility <i>Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Sepsis</i> Due to (or as a consequence of):  b. <i>End Stage Renal Disease</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dr. H. H. H. H.</i>				29c. License number <i>P 13373</i>		29d. Date signed (Month, Day, Year) <i>November 29, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARA DIVITS 29 Greene Street Baltimore MD 21201 (University of Maryland Medical Center)</i>											
31. Date filed (Month, Day, Year) <i>DEC 1 2000</i>				32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38197

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ISRAEL M ZELIGMAN</b>		2. Date of Death Month <b>NOV.</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>1:30PM</b>
4a. Facility Name (If not institution, give street and number) <b>4001 CLARKS LANE, APT. 205</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>217-14-6889</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>FEB. 14, 1916</b>		9. Birthplace (State or Foreign Country) <b>LATVIA</b>		
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>4001 CLARKS LANE #205</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CERTIFIED PUBLIC ACCOUNTANT</b>		16b. Kind of Business/Industry <b>ACCOUNTING</b>
17. Father's Name (First, Middle, Last) <b>MICHAEL ZELIGMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE (UNKNOWN)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JACOB COHEN / FRIEND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3313 LIGHTFOOT DRIVE - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHIZUK AMUNO (ARLINGTON)</b>		Date <b>11/30/00</b>
20c. Location - City or Town, State <b>BALTIMORE, MD</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC</b> <b>8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma of Stomach</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number <b>D27123</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jacob Minkov 750 Main St Reisterstown, MD 21136</b>				
31. Date filed (Month, Day, Year) <b>DEC - 1 2000</b>		32. Registrar's Signature 		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clyde Noel Atwell				2. Date of Death Month Day Year November 20 2000				3. Time of Death 2:25 PM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-30-9786		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) June 25, 1935		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 186 Woods Drive				10f. Zip Code 21403	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-61	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics Technician				16b. Kind of Business/Industry U.S. Govt.				17. Father's Name (First, Middle, Last) Clyde Franklin Atwell	
	18. Mother's Name (First, Middle, Maiden Surname) Elnora D. Wilde				19a. Informant's Name/Relationship (Type, Print) Mary J. Atwell / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 Woods Drive Annapolis, MD. 21403	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Quaker Burial Grounds 11-25-00				20c. Location - City or Town, State West River, MD.	
	21. Signature of Funeral Service Licensee C. Brian Powell				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer	
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier John D. Jackson M.D.				29c. License number 030718		
29d. Date signed (Month, Day, Year) 11-21-2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John D. Jackson, M.D. 2003 Medical Parkway Suite 100 Annapolis, MD. 21401				31. Date filed (Month, Day, Year) NOV 21 2000		
32. Registrar's Signature [Signature]				33. State Registrar [Signature]				34. State Registrar [Signature]		

ORIGINAL



00 38199

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Iva Marie Burkholder				2. DATE OF DEATH MONTH 11-13-2000 DAY YEAR		3. TIME OF DEATH 18:30 P M	
4. SOCIAL SECURITY NUMBER 578-34-0130		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-14-1906	
8. BIRTHPLACE (State or Foreign Country) Minnesota				9a. FACILITY NAME (If not institution, give street and number) Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Damascus				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10200 Moxley Road	
10f. ZIP CODE 20872				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY Health Food Store	
17. FATHER'S NAME (First, Middle, Last) John Goard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Melissa Brist			
19a. INFORMANT'S NAME (Type/Print) Joan M. Burkholder - Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10200 Moxley Road, Damascus, Maryland 20872			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 11/18 Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert L. Williams</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 5 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert L. Williams</i>		29c. LICENSE NUMBER D-13971		29d. DATE SIGNED (Month, Day, Year) 11/14/00			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 300 W. 9th St. Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) NOV 16 2000		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38200

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Peggy Delores BARGER				2. Date of Death Month Day Year Nov 18 2000		3. Time of Death 0704AM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 217-28-5705	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	8. Date of Birth (Month, Day, Year) June 24 1933	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 11214 Hollywppd Road				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Janitor		16b. Kind of Business/Industry Janitorial Service		
17. Father's Name (First, Middle, Last) Howard Herman Barnhart				18. Mother's Name (First, Middle, Maiden Surname) Kathleen Zombro				
19a. Informant's Name/Relationship (Type, Print) Karen Wiley - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Pope Avenue Hagerstown, Maryland 21740				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		20c. Location - City or Town, State 11/21/00 Hagerstown, Maryland		
21. Signature of Funeral Service Licensee Fred L. Ventral				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Chronic obstructive pulmonary disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier D. Quoo				29c. License number 021457		29d. Date signed (Month, Day, Year) 11-19-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL WAHED, MD - 12821 OAKHILL AVE. HAGERSTOWN. MD								
31. Date filed (Month, Day, Year) NOV 20 2000				32. Registrar's Signature B Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: BARGER, PEGGY DELORES  
06/24/1933 67 / F

DOS: 11/14/2000  
WAHEED, ABDUL



H3042353692



H244935



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 26 Per Phy. 11/16/00 AACO HEALTH CMH

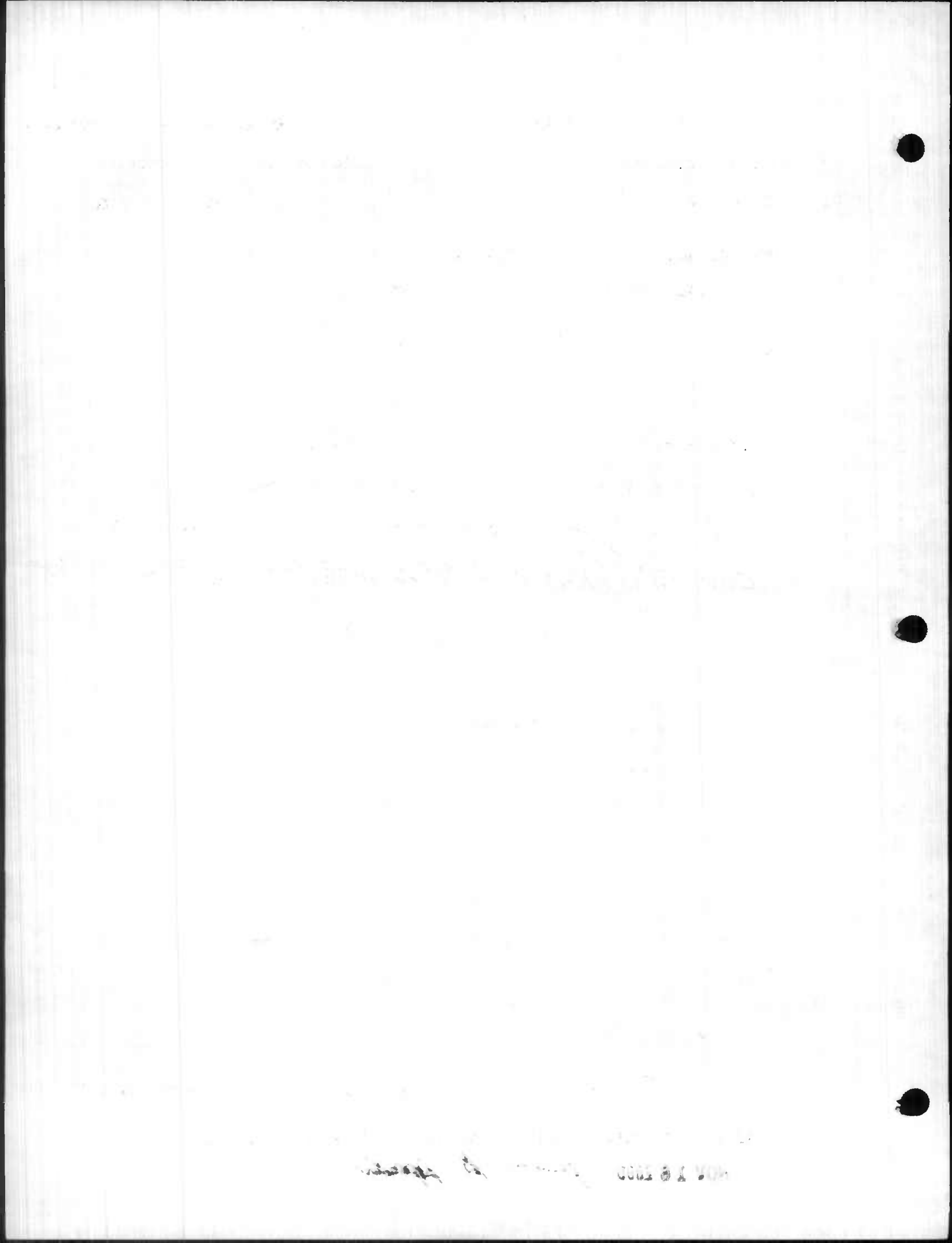
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38201

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY BULL</b>				2. Date of Death Month <b>November</b> Day <b>12</b> , Year <b>2000</b>		3. Time of Death <b>5:05 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>5816 Cornstack Road</b>				4b. City, Town, or Location of Death <b>Marion Station</b>		4c. County of Death <b>Somerset</b>	
Funeral Director	5. Social Security Number <b>213-34-6482</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1937</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>FL</b>		10b. County <b>Polk</b>		10c. City, Town or Location <b>Lakeland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>10905 Country Haven Drive</b>				10f. Zip Code <b>33809</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Barmaid</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
	17. Father's Name (First, Middle, Last) <b>Edward Propst, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Richards</b>			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Vicky Graves/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 Buena Vista Ave, Arnold, MD 21012</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>Nov 17, 2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiorespiratory Arrest</b> Due to (or as a consequence of): <b>b. Cerebral Metastases</b> Due to (or as a consequence of): <b>c. Bronchogenic Carcinoma</b> Due to (or as a consequence of): <b>d.</b>							
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Daughters Residence</b>			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D 15715</b>		29d. Date signed (Month, Day, Year) <b>November 13, 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>William Gill, M.D. - 26423 Burton Avenue - Crisfield, MD 21817</b>								
31. Date filed (Month, Day, Year) <b>NOV 16 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

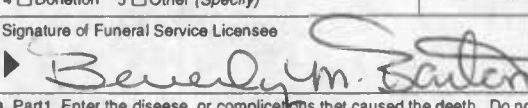
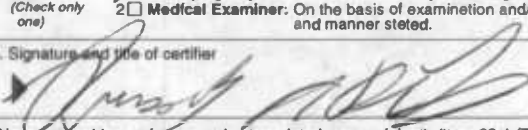
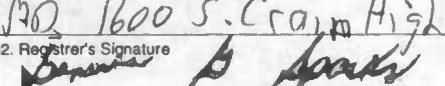


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38202

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Edward Bailey</b>				2. Date of Death Month <b>November</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>7:30 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Chesapeake Hospice House</b>				4b. City, Town, or Location of Death <b>Linthicum</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>719166382</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>November 22, 1921</b>	9. Birthplace (State or Foreign Country) <b>Tennessee</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Brooklyn Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>601 Biscay Avenue</b>			10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>			16b. Kind of Business/Industry <b>Security</b>	
	17. Father's Name (First, Middle, Last) <b>Walter Guess</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Bailey</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Theresa Bailey / Grand Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>601 Biscay Avenue, Brooklyn Park, MD 21225</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		Date <b>11/16/2000</b>	20c. Location - City or Town, State <b>Davidsonville, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>John M. Taylor Funeral Home/ Annapolis, MD 21401</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Lung Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death <b>4 mos.</b>						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice/HoChesapeake Hospice House</b>	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 			29c. License number <b>031551</b>		29d. Date signed (Month, Day, Year) <b>November 13, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell DeLuca, MD 1600 S. Crain Highway, Ste 602, Glen Burnie, MD 21061</b>						
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 16 2000</b>		32. Registrar's Signature 				

Handwritten signature or initials

NOV 18 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38203

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY BELT				2. Date of Death Month Day Year NOV. 7 2000				3. Time of Death 1230	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 215-28-4276		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 9 1930		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 952 SHERWOOD FOREST RD.				10f. Zip Code 21401				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPING				16b. Kind of Business/Industry CROWNSVILLE HOSPITAL	
	17. Father's Name (First, Middle, Last) BENJAMIN F. DORSEY				18. Mother's Name (First, Middle, Maiden Surname) MARY F. DORSEY					
	19a. Informant's Name/Relationship (Type, Print) MALINDA TRUXON (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 952 SHERWOOD FOREST RD. ANNAPOLIS, MD. 21401					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. TABOR CHURCH CEME.				20c. Location - City or Town, State 11/13/00 CHESTERFIELD, MD.	
	21. Signature of Funeral Service Licensee Larry D. Reese M00483				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	28d. Describe how injury occurred									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Anne Curran				29c. License number D46816				29d. Date signed (Month, Day, Year) 11/8/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL CHOPRA 7575 Ritchie Hwy Annapolis, Md.									
	31. Date filed (Month, Day, Year) NOV 15 2000				32. Registrar's Signature [Signature]					

NOV 12 1969



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38204

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELEANORA B. BARNES</b>				2. Date of Death Month Day Year <b>NOV. 10 2000</b>				3. Time of Death <b>0140 am</b>					
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>				4c. County of Death <b>ANNE ARUNDEL</b>					
Funeral Director	5. Social Security Number <b>219-34-6790</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>FEB. 23 1926</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>9 parole street</b>				10f. Zip Code <b>21401</b>				10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>				16b. Kind of Business/Industry <b>OUT OF THE HOME</b>					
	17. Father's Name (First, Middle, Last) <b>HARRISON N. BARNES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL MITCHELL</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>HOWARD M. BARNES (BROTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>544 McMECHEN ST. BALTIMORE, MD. 21217</b>									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS</b>				20c. Location - City or Town, State <b>11/15/00 ANNAPOLIS, MD.</b>					
	21. Signature of Funeral Service Licensee <i>Larry D. Reese</i> <b>MO0483</b>				22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Breast cancer</b>												Approximate Interval Between Onset and Death <b>3m</b>	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day Year)												28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier <i>Larry D. Reese</i>												29c. License number <b>032036</b>		
29d. Date signed (Month, Day, Year) <b>11/10/2000</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary S. Spruce, MD 2108 D. Donub Drive Chula, MD 21619</b>														
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>												32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38205

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN CRAY CANNON

2. Date of Death

Month Day Year  
NOV. 10, 2000

3. Time of Death

9:10 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARTLEY HALL NURSING HOME

4b. City, Town, or Location of Death

POCOMOKE

4c. County of Death

WORCESTER

5. Social Security Number

216-10-8837

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 18, 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

POCOMOKE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1006 MARKET ST.

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

JOSEPH BOWEN

18. Mother's Name (First, Middle, Maiden Summa)

MARY (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

GLORIA MAE DRYDEN - NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 MARKET ST., POCOMOKE, MD 21851-1205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SILVERBROOK CEMETERY

Date

11-14-00

20c. Location - City or Town, State

WILMINGTON, DE

21. Signature of Funeral Service Licensee

*George M. Short*

22. Name and Address of Facility

SHORT FUNERAL SERVICES, INC.  
416 FEDERAL ST., MILTON, DE 19968

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *End Stage Senile Dementia, Vascular Type*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*5 yrs*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Arteriosclerotic Cardiovascular Disease  
Chronic Renal Disease; Essential Hypertension  
Chronic Obstructive Pulmonary Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Gregorio M. Belluso M.D.*

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

11-11-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 15 2000

32. Registrar's Signature

*Sparks*

Helen Cannon  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1960-1961

John A. Smith

NOV 1 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38206

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH CAREY

2. Date of Death

November 14 2000 1819

3. Time of Death

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

219-42-8043

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 8, 1944

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1002 SOUTH SCHUMAKER DRIVE

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

JOHN LASLEY

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA YANCY

19a. Informant's Name/Relationship (Type, Print)

GEORGE C. CAREY - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1002 S SCHUMAKER DR SALISBURY, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CAMBRIDGE CREMATORY

Date

11/15/00

20c. Location - City or Town, State

CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

Miss [Signature]

22. Name and Address of Facility

705 E. MAIN ST.  
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Massive upper GI Bleeding  
Due to (or as a consequence of):b. Gallbladder - Weiss Tear  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Myeloma, Dehydration  
Acute Gastroenteritis, Anemia  
Hypomycytopenia, severe

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

757670

29d. Date signed (Month, Day, Year)

11/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Lito M. Evangelista

105 Pine Bluff Road  
Salisbury, MD 21801

31. Date filed (Month, Day, Year)

NOV 15 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Judith Howard Carey  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 12 2000  
Haupt B. ...



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38207

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Adeline Cramer</b>				2. Date of Death Month <b>November</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>10:40 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>215-20-8061</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 6, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5629 Shaw Drive</b>		10f. Zip Code <b>21704</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>7</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>seamstress</b>		16b. Kind of Business/Industry <b>clothing company</b>			
	17. Father's Name (First, Middle, Last) <b>Rocco Guariglia, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillie McDonald</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Elva J. Shaw / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5629 Shaw Drive, Frederick, MD 21704</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		20c. Location - City or Town, State <b>11/11/00 Frederick, MD</b>			
	21. Signature of Funeral Service Licensee <i>Maureen Kien</i>				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death <b>7 days</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year) <b>11/11/00</b>								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how Injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dr. Halvorson</i>								
29c. License number <b>122101</b>								
29d. Date signed (Month, Day, Year) <b>11/11/00</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Hayd Halvorson 475 King Ave. Frederick Md 21702</b>								
31. Date filed (Month, Day, Year) <b>NOV 13 2000</b>								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38208

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Louis Crouse II				2. Date of Death Month Day Year November 8, 2000		3. Time of Death 3:40 P.M.	
	4a. Facility Name (If not institution, give street and number) 116 West Fourth Street				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 217-88-7593	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 21, 1962		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 116 West Fourth Street			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Certified Welder		16b. Kind of Business/Industry Contractors			
	17. Father's Name (First, Middle, Last) John Franklin Crouse, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Shirley Ann Jenkins			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Tina A. Dorsey/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 West Fourth Street, Frederick, Md. 21701			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date Nov. 11, 2000		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard C. Basford		22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE MYELOGENOUS LEUKEMIA Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Bryan M. O'Connor, MD		29c. License number D31761		29d. Date signed (Month, Day, Year) 11/10/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bryan M. O'Connor MD 581 W. SEVENTH ST., FREDERICK, MD 21701								
State Registrar	31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature Bryan M. O'Connor					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38209

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Faherty Casey</b>		2. Date of Death Month <b>November</b> Day <b>6</b> Year <b>2000</b>		3. Time of Death <b>6:40 am</b>
	4e. Facility Name (If not institution, give street and number) <b>6714 Deer Spring Lane</b>		4b. City, Town, or Location of Death <b>Braddock Heights</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>496-38-0424</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month Day Year <b>Jan 31, 1939</b>		9. Birthplace (State or Foreign Country) <b>Missouri</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Braddock Heights</b>	
10e. Street and Number <b>6714 Deer Spring Lane</b>		10f. Zip Code <b>21714</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Depty Dir Field Programs</b>	
17. Father's Name (First, Middle, Last) <b>Anthony Aloysius Casey Sr</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Mary Pinkley</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Maxine Bryan Casey/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6714 Deer Spring Lane, Braddock Heights, MD 21714</b>			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		20c. Location - City or Town, State <b>Frederick, MD</b>	
21. Signature of Funeral Service Licensee  <b>MO0706</b>		22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church Street, Frederick, MD 21701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. <b>Cerebral aneurysm</b>		Due to (or as a consequence of):			
b. <b>Myocardial infarction</b>		Due to (or as a consequence of):			
c. <b>Kidney cancer</b>		Due to (or as a consequence of):			
d. <b>39-5</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D14626</b>		29d. Date signed (Month, Day, Year) <b>Nov 6, 2000</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, Maryland 21701</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 08 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38210

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Emmet Crane				2. Date of Death Month Day Year November 19, 2000		3. Time of Death 11:10 AM	
	4a. Facility Name (If not institution, give street and number) Heritage Harbour Health and Rehab Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 140-24-8589		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 18, 1930	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Gambrills	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2524 Davidsonville Road		10f. Zip Code 21054		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1952-54		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trade Routes Examiner		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) John Crane	
	18. Mother's Name (First, Middle, Maiden Surname) Freida Delling		19a. Informant's Name/Relationship (Type, Print) Norma Crane/wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2524 Davidsonville Rd. Gambrills, MD 21054		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery		20c. Date 11/27/00		20d. Location - City or Town, State Cheltenham, MD		21. Signature of Funeral Service Licensee J. E. Liller	
	22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) prostatic carcinoma		Approximate Interval Between Onset and Death 6 1/2 yrs		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
To Be Completed by Physician/Medical Examiner	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier J. Selonick	
	29c. License number D19838		29d. Date signed (Month, Day, Year) 11/20/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart E. Selonick, M.D. 900 Bestgate Rd. Annapolis, Md. 21401		31. Date filed (Month, Day, Year) NOV 21 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature [Signature]		33. State Registrar [Signature]		34. State Registrar [Signature]		35. State Registrar [Signature]	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38211

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET MARY CRUMRINE				2. Date of Death Month Day Year NOVEMBER 2, 2000		3. Time of Death 11:10 AM														
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick														
Funeral Director	5. Social Security Number 297-22-3069		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 23, 1920														
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick														
Usual Residence of Decedent																					
10a. State Maryland				10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
10e. Street and Number 990 Waterford Drive				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.															
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Elementary School															
17. Father's Name (First, Middle, Last) Paul Boyce					18. Mother's Name (First, Middle, Maiden Surname) Mathilda LeGroes																
19a. Informant's Name/Relationship (Type, Print) Joyce DeBow (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7991 Schooner Court, Frederick, Maryland 21701																
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 11/3/00		20c. Location - City or Town, State Smithsburg, Maryland														
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>CONGESTIVE HEART FAILURE</td> <td>2 days</td> </tr> <tr> <td>b.</td> <td>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</td> <td>UNKNOWN</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	CONGESTIVE HEART FAILURE	2 days	b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	UNKNOWN	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	CONGESTIVE HEART FAILURE	2 days																		
	b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	UNKNOWN																		
	c.																				
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)															
			28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier George I. Smith M.D. VPMH			29c. License number D10587		29d. Date signed (Month, Day, Year) 11/3/2000													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE I. SMITH, M.D. VICE PRES MED. AFFAIRS FREDERICK MEMORIAL HOSPITAL FREDERICK, MD 21701																					
31. Date filed (Month, Day, Year) NOV 06 2000			32. Registrar's Signature 																		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 4035

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wm. D. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38212

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fern Alverta Dietz				2. Date of Death Month November Day 16, Year 2000		3. Time of Death 2:30 AM	
	4a. Facility Name (If not institution, give street and number) 705 Whitehall Plains Road				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-20-2487		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 11, 1927	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 705 Whitehall Plains Road		10f. Zip Code 21401	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clerk	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail				16b. Kind of Business/Industry Retail		17. Father's Name (First, Middle, Last) Ernest Rittershofer	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Edna Marsh				19a. Informant's Name/Relationship (Type, Print) Robert Dietz/husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Whitehall Plains Road Annapolis, MD 21401	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Todd E. Liller				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 yr							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Atty J. Wetherman Jr				29c. License number D08118		29d. Date signed (Month, Day, Year) 11/16/2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLEY WATKINS JR MD 900 BESTGATE RD ANNAPOLIS MD 21401							
	31. Date filed (Month, Day, Year) NOV 17 2000				32. Registrar's Signature [Signature]			

ORIGINAL

Handwritten scribbles

NOV 1 1944

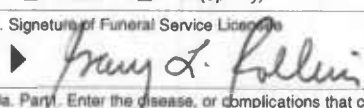
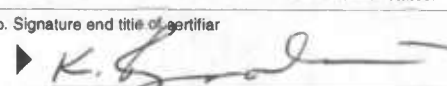



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38213

Amended item#3 &amp; 26 FCHD,KS 11/13/00 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MACK EVANS</b>		2. Date of Death Month Day Year <b>NOV. 8, 2000</b>		3. Time of Death <b>unknown a.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>240 WEST SOUTH ST. APT. 8</b>		4b. City, Town, or Location of Death <b>FREDERICK</b>		4c. County of Death <b>FREDERICK</b>
Funeral Director	5. Social Security Number <b>244-01-8227</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>AUG. 11, 1911</b>		9. Birthplace (State or Foreign Country) <b>md.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD.</b>	10b. County <b>FREDERICK</b>	10c. City, Town or Location <b>FREDERICK</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>240 WEST SOUTH ST APT 8</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3 RD</b> College (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF-EMPLOYED</b>		16b. Kind of Business/Industry <b>RESTAURANT</b>		
	17. Father's Name (First, Middle, Last) <b>(Unknown)</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>OLIVE E. BAILEY</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Jackie Evans Jones Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 West South St. Frederick, MD 21701</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Cemetery</b>		20c. Location - City or Town, State <b>11-14-00 Fred., MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gary L. Rollins Funeral Home 110 West South St. Frederick, MD 21701</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Coronary artery disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number <b>221648</b>					
29d. Date signed (Month, Day, Year) <b>11-13-00</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>KUSAY BARAKAT 310 W 9th Street Frederick MD 21701</b>					
31. Date filed (Month, Day, Year) <b>NOV 13 2000</b>					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38214

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT J EHRLINGER</b>				2. Date of Death Month Day Year <b>NOVEMBER 7, 2000</b>		3. Time of Death <b>4:40 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>175-22-0277</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 11, 1923</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>New Market</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6527 Rimrock Road</b>				10f. Zip Code <b>21774</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>Research</b>	
17. Father's Name (First, Middle, Last) <b>Carl Henry Ehrlinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Dorothy Wessler</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Ehrlinger, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6527 Rimrock Road, New Market, Maryland 21774</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>11/9/2000</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Ryan M. B...</i>				22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b> <b>MO0999 106 East Church Street, Frederick, Maryland 21701</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 Days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Robert L. Kaufman</i>			29c. License number <b>D-13971</b>		29d. Date signed (Month, Day, Year) <b>11/7/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert L. Kaufman, MD 300 West 9th Street Frederick, Maryland</b>								
31. Date filed (Month, Day, Year) <b>NOV 13 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38215

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elva Lee Eilertson</b>				2. Date of Death Month Day Year <b>November 5, 2000</b>		3. Time of Death <b>10:45am</b>	
	4a. Facility Name (If not institution, give street and number) <b>4006 Middleton Drive</b>				4b. City, Town, or Location of Death <b>Monrovia</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>218-30-3244</b>		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		If Under 1 Year Months Days	
	6. Date of Birth (Month, Day, Year) <b>Dec. 9, 1934</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b>				10b. County <b>Frederick</b>			
	10c. City, Town or Location <b>Monrovia</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>4006 Middleton Drive</b>				10f. Zip Code <b>21770</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Aid</b>		16b. Kind of Business/Industry <b>University of Maryland</b>			
	17. Father's Name (First, Middle, Last) <b>William Wilson Pearrell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Tabler</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Edward V. Eilertson/ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4006 Middleton Drive, Monrovia, Maryland 21770</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Falling Waters Pres. Cemetery 11/8</b>		20c. Location - City or Town, State <b>Hedgesville, W. Virginia</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Olin L. Molesworth P. A. Funeral Home</b> <b>26401 Ridge Road, Damsacus, Maryland 20872</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart Failure</b> Due to (or as a consequence of): <b>b. HEART FAILURE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>MITRAL REGURGITATION</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MITRAL REGURGITATION</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>027544</b>		29d. Date signed (Month, Day, Year) <b>11/6/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John A. Vitarello M.D. 180 Thomas Johnson Drive, Frederick Maryland Suite 202</b>								
31. Date filed (Month, Day, Year) <b>NOV 08 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38216

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard Edison Eader</b>				2. Date of Death Month <b>Nov.</b> Day <b>2,</b> Year <b>2000</b>				3. Time of Death <b>6 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>4946 Flossie Ave.</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>213-40-6921</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth Month <b>July</b> Day <b>5,</b> Year <b>1940</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>		
	Usual Residence of Decedent				10a. State <b>MD.</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No
10e. Street and Number <b>4946 Flossie Ave.</b>				10f. Zip Code <b>21703</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>plumbing</b>				16b. Kind of Business/Industry <b>construction</b>			
17. Father's Name (First, Middle, Last) <b>Lewis Blaine Eader</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Roberts</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Donna J. Eader (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4946 Flossie Ave., Frederick, MD. 21703</b>							
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>				Date <b>11/6</b>		20c. Location - City or Town, State <b>Smithsburg, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald B. Thompson Funeral Home</b> <b>31 E. Main St., Middletown, MD. 21769</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Heart Failure (Artery)</u></b> Due to (or as a consequence of):  <b>b. <u>Recurrent colon CA</u></b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>2 weeks</b>  <b>10 yrs</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
								24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number <b>174575</b>				29d. Date signed (Month, Day, Year) <b>Nov 9, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PA [Signature] 501 W 7th St Frederick MD 21701</b>											
31. Date filed (Month, Day, Year) <b>NOV 08 2000</b>				32. Registrar's Signature 							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38217

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Regina Elizabeth ECKARD				2. Date of Death Month Day Year November 17, 2000		3. Time of Death 5:45 p. m.		
	4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington		
Funeral Director	5. Social Security Number 214-09-4650		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1912		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 13026 Salem Avenue		10f. Zip Code 21740		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor		16b. Kind of Business/Industry hosiery co.					
17. Father's Name (First, Middle, Last) George H. Koogle				18. Mother's Name (First, Middle, Maiden Surname) Nora Cashman					
19a. Informant's Name/Relationship (Type, Print) John Koogle, Sr. - brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10638 Peach Tree Lane, Williamsport, Md. 21795					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		Date 11-21-2000		20c. Location - City or Town, State Hagerstown, Md.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Aspiration Pneumonia Due to (or as a consequence of): b. Organic brain Syndrome Due to (or as a consequence of): c. Senility Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 2 weeks years. years.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Gastrointestinal hemorrhage  Atherosclerosis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D44996		29d. Date signed (Month, Day, Year) November 19, 2000.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO, MD 21713		31. Date filed (Month, Day, Year) NOV 22 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38218

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALDINE ELLIS				2. Date of Death Month Day Year NOV. 8 2000		3. Time of Death 0900	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 339-14-5980		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 7 1917	
	9. Birthplace (State or Foreign Country) MISSISSIPPI		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 59 REGATTA BAY CT. #166		10f. Zip Code 21401	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUYER				16b. Kind of Business/Industry SPIEGAL COMPANY			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JAMES MORGAN				18. Mother's Name (First, Middle, Maiden Surname) ANNA CROSSLEY			
	19a. Informant's Name/Relationship (Type, Print) GWENDOLYN FOSTER (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 REGATTA BAY CT. #166 ANNAPOLIS, MD. 21401			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) OAKWOOD CEMETERY		20c. Location - City or Town, State 11/14/00 CHICAGO, ILL.	
	21. Signature of Funeral Service Licensee Harry D. Reese M00482				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Anoxic Encephalopathy Due to (or as a consequence of): b. Ventricular Cardiac Arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death mins mins	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier [Signature]	
To Be Completed by Physician/Medical Examiner	29c. License number DM35494						29d. Date signed (Month, Day, Year) 11/09/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Resnick Anne Arundel Medical Center ANNAP, MD 21401							
State Registrar	31. Date filed (Month, Day, Year) NOV 15 2000				32. Registrar's Signature [Signature]			

ORIGINAL

NOV 1 2 1966



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38219

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Elsie Fiertner				2. Date of Death Month Day Year November 15, 2000				3. Time of Death 7:35 PM			
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick			
Funeral Director	5. Social Security Number 081-07-7586		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 17, 1914		9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Ijamsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10a. Street and Number 2026 Fire Tower Lane				10f. Zip Code 21754		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Albert Lessmann				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Kleinsteinuber							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy Voketitis, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2026 Fire Tower Lane, Ijamsville, Md. 21754							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ferncliff Cemetery, Nov. 20, 2000				20c. Location - City or Town, State Hartsdale, New York			
	21. Signature of Funeral Service Licensee ► Richard E. Hraf MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  C.V.A.  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Diabetic mellitus, Hypertension								Approximate Interval Between Onset and Death 3 days			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetic mellitus, Hypertension				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier ► [Signature]				29c. License number D21944		29d. Date signed (Month, Day, Year) November 16, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James S. Grisson, 300 W. 9th St. Frederick, Md. 21701											
31. Date filed (Month, Day, Year) NOV 17 2000				32. Registrar's Signature [Signature]								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38220

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Londa Noreen Frye				2. Date of Death Month: November Day: 13, Year: 2000				3. Time of Death 6:28 pm		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 216-60-8119		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth Month: Nov. Day: 26, Year: 1952		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 136 East South Street				10f. Zip Code 21701				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Lonzo Emory Snoots				18. Mother's Name (First, Middle, Maiden Surname) Hilda Blanche Tregoning							
19a. Informant's Name/Relationship (Type, Print) Damon E. Frye, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 W. Orndorff Dr., Brunswick, Maryland 21716							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Nov. 16, 2000				20c. Location - City or Town, State Frederick, Maryland			
21. Signature of Funeral Service Licensee Richard E. Harg M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 8 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arthritis Diabetes mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Richard E. Harg				29c. License number A 22109				29d. Date signed (Month, Day, Year) 11/15/00			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lloyd Anderson 1475 Long Ave. Frederick Md 21702											
31. Date filed (Month, Day, Year) NOV 16 2000				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38221

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frieda B. Frazier				2. Date of Death Month Day Year November 19, 2000				3. Time of Death 4:17 PM			
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Spa Creek				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 214-26-0403		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) September 6, 1914		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 3023 Arundel On the Bay Road				10f. Zip Code 21403		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary School Teacher			16b. Kind of Business/Industry Education				
	17. Father's Name (First, Middle, Last) William Bast				18. Mother's Name (First, Middle, Maiden Surname) Christine Welker							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Deena D. Frazier-Hoffman (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Chester St., Arlington, MA 02476							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens		Date 11/24/00		20c. Location - City or Town, State Annapolis, MD					
	21. Signature of Funeral Service Licensee ▶ Todd E. Liller		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401									
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Coronary vascular accident</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 wk	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier ▶ [Signature]		29c. License number D32036		29d. Date signed (Month, Day, Year) 11/20/2000					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gay J. Sprave 2108 D. Dunbar Drive Chester MD 21619											
State Registrar	31. Date filed (Month, Day, Year) NOV 21 2000				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

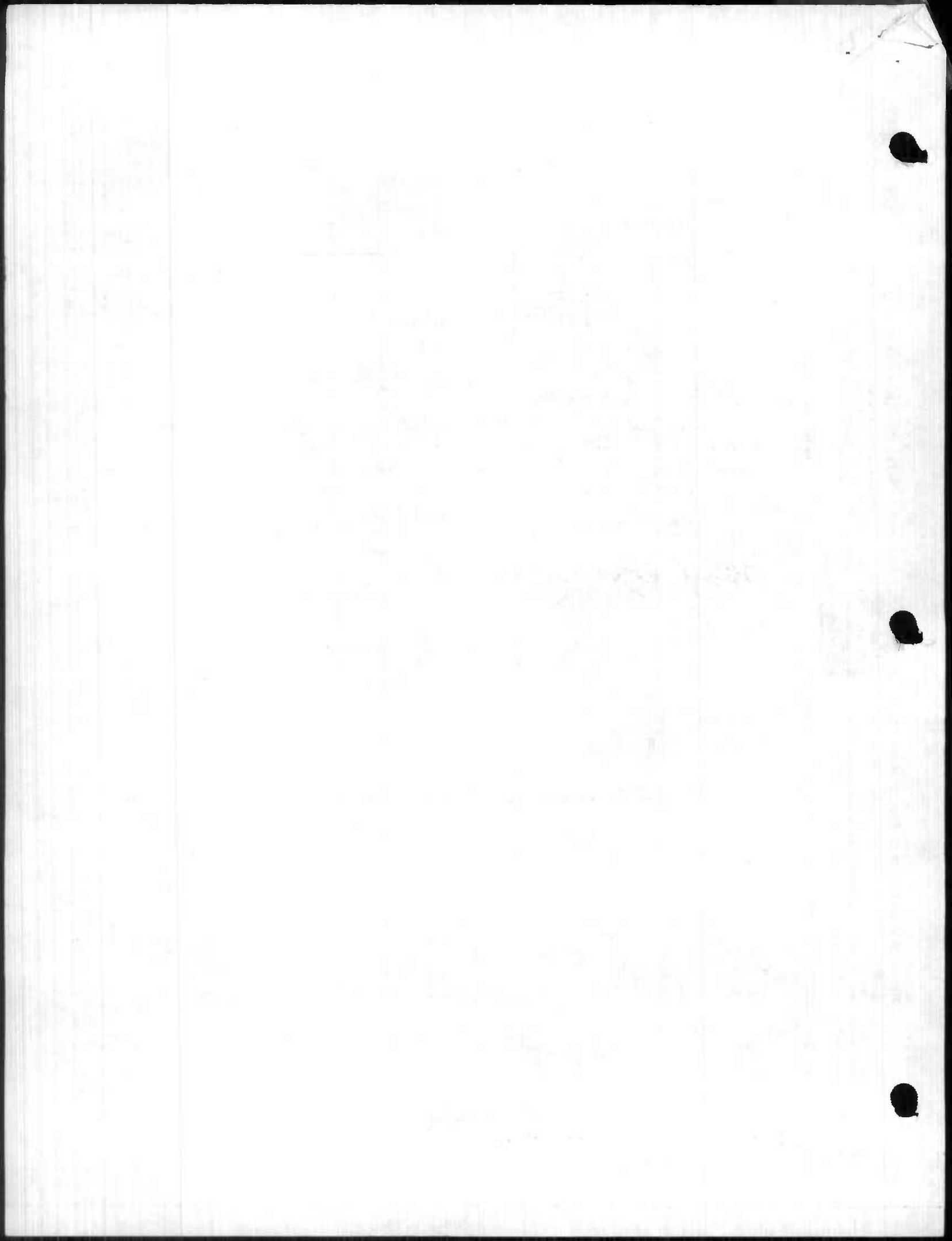
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLORENCE WILSON GEORGE				2. Date of Death Month Day Year November 15, 2000		3. Time of Death 0545		
	4a. Facility Name (If not institution, give street and number) Julia Manor Health Care Center				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County		
Funeral Director	5. Social Security Number 220-16-4048		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 13, 1925	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Washington Co.		10c. City, Town or Location Hagerstown Williamsport			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 14 Oak Tree Lane, Apt. G				10f. Zip Code 21740 21795		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Retail Store		
17. Father's Name (First, Middle, Last) Herman Waverly Gilliam				18. Mother's Name (First, Middle, Maiden Surname) Gracie Edna Mays					
19a. Informant's Name/Relationship (Type, Print) Delores Y. Lebo, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17822 Woodcrest Road, Hagerstown, Maryland 21740					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park		Date Nov. 18		20c. Location - City or Town, State Hagerstown, Maryland			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742					
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>ESOPHAGEAL CARCINOMA</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Approximate Interval Between Onset and Death <u>4 months</u>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D26523		29d. Date signed (Month, Day, Year) November 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINO J. DELAPORTA JR 11110 MEDICAL CENTER ROAD HAGERSTOWN MD 21742									
31. Date filed (Month, Day, Year) NOV 20 2000				32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38223

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence

Rosalie

GOSSARD

2. Date of Death

Month

Day

Year

NOV

20

2000

3. Time of Death

0710.A

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

216-38-0936

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 3, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15640 Broadfording Rd.

10f. Zip Code

21722

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Adolphus

H.

Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Kate

Palmer

19a. Informant's Name/Relationship (Type, Print)

Linda Webb (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15640 Broadfording Rd. Clear Spring, MD 21722

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from state4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Nov. 20, 2000

Date

20c. Location - City or Town, State

Smithsburg, MD 21783

21. Signature of Funeral Service Liaison

22. Name and Address of Facility

OSBORNE FUNERAL HOME

P.O. Box # 348 Williamsport, MD 21795

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

1 M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

10 Y

c. HYPERTENSION

Due to (or as a consequence of):

10 Y

d. DIABETES MELLITIS

10 Y

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GOUT

ARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DS23 23

29d. Date signed (Month, Day, Year)

10/20/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Khalid Waseem, MD

Western Maryland Hospital Center

1500 Pennsylvania Avenue, Hagerstown, MD 21742-3112

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

Benjamin A Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38224

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY VIOLET GREGORY				2. Date of Death Month Day Year November 19 2000		3. Time of Death 8:10 PM	
	4a. Facility Name (If not institution, give street and number) REEDERS MEMORIAL HOME				4b. City, Town, or Location of Death BOONSBORO		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 229-16-2960		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 23, 1911	
	9. Birthplace (State or Foreign Country) WISCONSIN		10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location BOONSBORO	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 141 SOUTH MAIN STREET		10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) BUTLER R. STANLEY				18. Mother's Name (First, Middle, Maiden Surname) MARY JANE STANLEY			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BILLY JOE STANLEY/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6541 WASHINGTON MONUMENT RD, BOONSBORO, MD 21713			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		20c. Location - City or Town, State BOONSBORO, MARYLAND		20d. Date 11/22/00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Paul m. Dean				22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>adenocarcinoma of the liver</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3 weeks			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Dr. Robert Guedenet		29c. License number D32518	
	29d. Date signed (Month, Day, Year) 11/20/00				29e. Date filed (Month, Day, Year) NOV 21 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222				31. Date filed (Month, Day, Year) NOV 21 2000			
	32. Registrar's Signature Benita Sparks				33. Date filed (Month, Day, Year) NOV 21 2000			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38225

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Austin Fred Gunnell</b>				2. Date of Death Month <b>November</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>1513</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital Hagerstown</b>				4b. City, Town, or Location of Death <b>Washington</b>		4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>549-40-8566</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7-11-32</b>		
	9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>		10a. State <b>Pa</b>		10b. County <b>Fulton</b>		10c. City, Town or Location <b>McConnellsburg . Pa.</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>112 East Wood St.</b>		10f. Zip Code <b>17233</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>Sheet Metal Work</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sheet Metal Work</b>		16b. Kind of Business/Industry <b>LOCAL 100</b>					
17. Father's Name (First, Middle, Last) <b>Austin Fred Gunnell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel H. Woodbury</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Grace Gunnell - wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 East Wood St., McConnellsburg, Pa.</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Cemetery</b>		20c. Date <b>11-21-00</b>		20d. Location - City or Town, State <b>McConnellsburg, Pa.</b>			
21. Signature of Funeral Service Licensee <b>Eric D. Peterman</b>		22. Name and Address of Facility <b>Relso-Conceleus Fun. Home, Inc. 322 N. 3rd St. McConnellsburg, Pa.</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CARDIAC ARREST WITH VENTRICULAR FIBRILLATION 1hr</b> Due to (or as a consequence of):  b. <b>SEPSIS</b> Due to (or as a consequence of):  c. <b>RENAL FAILURE</b> Due to (or as a consequence of):  d. <b>ADRIAL FIBRILLATION with Rapid heart rate 1 Day</b>								Approximate Interval Between Onset and Death  <b>2 days</b>  <b>2 wks</b>  <b>1 Day</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>ADULT ONSET DIABETES</b>  <b>HYPERTENSION</b>								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>2</b> Medical Examiner		29b. Signature and title of certifier <b>Dr. West</b>		29c. License number <b>D44471</b>		29d. Date signed (Month, Day, Year) <b>11/20/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. West 11110 Medical Campus Rd Hager MD 21742</b>									
31. Date filed (Month, Day, Year) <b>NOV 21 2000</b>		32. Registrar's Signature <b>Benita B Sparks</b>							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38226

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maria Pura Garcia				2. Date of Death Month 11 Day 17 Year 2000				3. Time of Death 1:30 AM			
	4a. Facility Name (If not institution, give street and number) Prince George Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George			
Funeral Director	5. Social Security Number None		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 07-20-1914		9. Birthplace (State or Foreign Country) Spain			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George		10c. City, Town or Location District Heights				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2901 Logan Street				10f. Zip Code 20747		10g. Citizen of What Country? Spain & Uruguay					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dressmaker			16b. Kind of Business/Industry Fashion				
	17. Father's Name (First, Middle, Last) Emilio Garcia				18. Mother's Name (First, Middle, Maiden Surname) Maria Josefa Vazquez							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Myriam Roas				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Logan Street District Heights, MD. 20747							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 11/20/2000		20c. Location - City or Town, State Alexandria, Virginia			
	21. Signature of Funeral Service Licensee Melanie Williams				22. Name and Address of Facility Advent Funeral & Cremation Svcs. 7211 Lee Hwy Falls Church, Virginia 22046							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Critical Aortic Stenosis Due to (or as a consequence of): b. Metastatic cancer Due to (or as a consequence of): c. Acute Renal failure Due to (or as a consequence of): d. Multiple organ dysfunction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier		29c. License number D54357		29d. Date signed (Month, Day, Year) 11/17/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ebonda, Mpinga, MD 300 Hospite Drive, Cheverly MD.											
	31. Date filed (Month, Day, Year) 11 NOV 21 2000		32. Registrar's Signature [Signature]									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38227

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD H. GOLEMBIESKI</b>				2. Date of Death Month <b>11</b> Day <b>16</b> Year <b>80</b>		3. Time of Death <b>8:10 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1920 Marconi Circle</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>106-14-7283</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 30, 1911</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1920 Marconi Circle</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-47</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Director of Veterans Affairs</b>		16b. Kind of Business/Industry <b>American Legion National Office</b>		
17. Father's Name (First, Middle, Last) <b>Antoni Golembieski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julianna Kwiatkowska</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Helen F. Golembieski/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1920 Marconi Circle Annapolis, Maryland 21401</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		20c. Location - City or Town, State <b>11-20-00 Crownsville, Maryland</b>		
21. Signature of Funeral Home Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEVERE AORTIC STENOSIS</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  M.D.				29c. License number <b>D0021336</b>		29d. Date signed (Month, Day, Year) <b>11/17/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALBIN O. KUHN &amp; M.D. 8028 RITCHIE HIGHWAY, PASADENA, MARYLAND 21222</b>								
31. Date filed (Month, Day, Year) <b>NOV 20 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

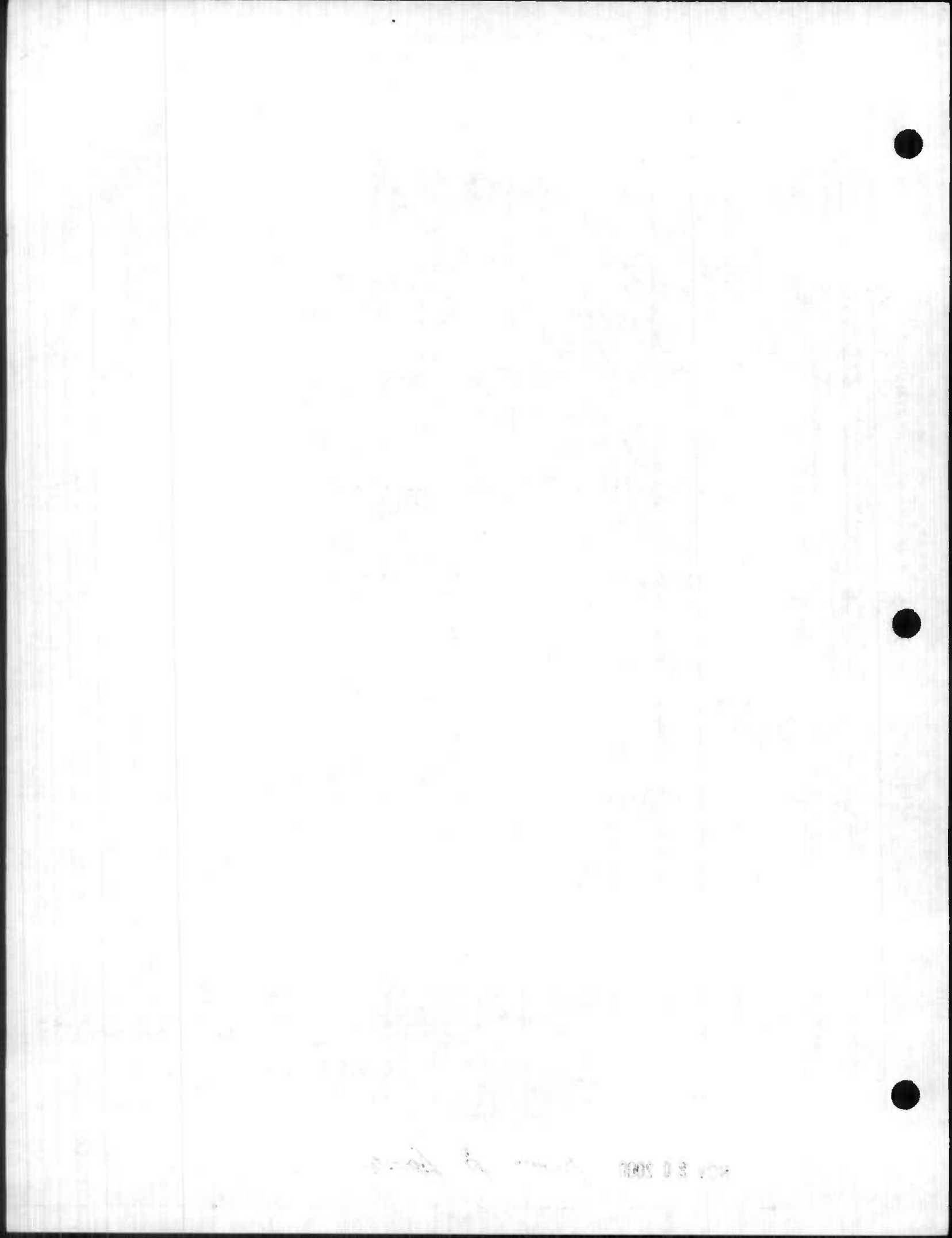
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38228

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarence Philip Handley, Jr.</b>				2. Date of Death Month Day Year <b>November 13, 2000</b>		3. Time of Death <b>11:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>225 East 4th Street</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>215-14-2859</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 7, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5301 New Design Road</b>		10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-44</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>self</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>self</b>		16b. Kind of Business/Industry <b>saddle making/horses</b>				
17. Father's Name (First, Middle, Last) <b>Clarence Philip Handley, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Marie Walters</b>				
19a. Informant's Name/Relationship (Type, Print) <b>M. Patricia Koogle, friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>225 East 4th Street, Frederick, MD 21701</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul's Lutheran Cem.</b>		20c. Location - City or Town, State <b>Jefferson, Maryland</b>		20d. Date <b>11/16</b>		
21. Signature of Funeral Service Licensee <b>Ryan M. Beger</b>		22. Name and Address of Facility <b>Keeney and Basford Funeral Home</b>		22b. License Number <b>M00999</b>		22c. Address <b>106 East Church Street, Frederick, MD 21701</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Prostate Cancer</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>{</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Years</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Friend's Home</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Andrew Zarick, Jr.</b>		29c. License number <b>D35164</b>		29d. Date signed (Month, Day, Year) <b>November 14, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703</b>								
31. Date filed (Month, Day, Year) <b>NOV 14 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38229

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Houck				2. Date of Death November 12, 2000		3. Time of Death 7:20 pm	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 217-10-0901		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 4, 1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Prince George		10c. City, Town or Location College Park	
To Be Completed by Funeral Director	10d. Inside City Limits XX Yes 2 <input type="checkbox"/> No				10e. Street and Number 7324 Baylor Avenue		10f. Zip Code 20740	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Jesse Carey	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Carrie Ranneberger				19a. Informant's Name/Relationship (Type, Print) Mr. Raymond H. Houck, Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7324 Baylor Ave., College Park, Md. 20740	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Nov. 15, 2000		20c. Location - City or Town, State Frederick, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Richard E. Prof M00255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. spinal cord injury Due to (or as a consequence of): b. cervical vertebra 1 and 2 fracture Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 days				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause of death. 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 11/9/2000		28b. Time of Injury 23:45p M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred Fell @ daughter's home			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) 5158 Doubs Road Adamstown, Maryland			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dennis Winters, M.D.			
To Be Completed by Physician/Medical Examiner	29c. License number 054619				29d. Date signed (Month, Day, Year) 11/13/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Winters, M.D., 198 Thomas Johnson Drive, Frederick, Maryland 21702				31. Date filed (Month, Day, Year) NOV 14 2000			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature [Signature]				33. Registrar's Signature [Signature]			
	34. Registrar's Signature [Signature]				35. Registrar's Signature [Signature]			

ORIGINAL




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38230

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gwendolyn Glass Harris				2. Date of Death Month: November Day: 6, Year: 2000		3. Time of Death 12:15pm	
	4a. Facility Name (If not Institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 414-30-6288		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 13, 1926	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Monrovia	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4559 Kempton Court		10f. Zip Code 21770		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Leon Polk Glass		18. Mother's Name (First, Middle, Maiden Surname) Marie Fitzgerald		19a. Informant's Name/Relationship (Type, Print) Carol Spicer/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 143 Monrovia, Maryland 21770	
To Be Completed by Funeral Director	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Frederick, Maryland		20d. Date 11/9/2000	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. MULTISYSTEM FAILURE Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 WEEKS 2 MONTHS			
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CROHNS DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Virendra K Saxena CRITICAL CARE CONSULTANT		29c. License number D30112		29d. Date signed (Month, Day, Year) November 06 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRENDRA K SAXENA, MD 15805 MARATHON CIR. #301, GAITHERSBURG MD 20878		31. Date filed (Month, Day, Year) NOV 08 2000					
	32. Registrar's Signature 							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38231

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Curtis Ray Huff</b>				2. Date of Death Month Day Year <b>November 3 2000</b>				3. Time of Death <b>6:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4021 Twin Arch Road</b>				4b. City, Town, or Location of Death <b>Mount Airy</b>				4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>235-60-9458</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Jan. 30, 1939</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Mount Airy</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4021 Twin Arch Road</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Public Schools</b>		17. Father's Name (First, Middle, Last) <b>Stanley Ray Huff</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel Sizemore</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Linda C. Huff / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4021 Twin Arch Road Mount Airy, Maryland 21771</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Blue Ridge Mem. Cemetery</b>		20c. Location - City or Town, State <b>Prosperity, West Virginia</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Fungal infection</b> Due to (or as a consequence of): <b>Chronic lymphocytic leukemia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>9 months</b>		Approximate Interval Between Onset and Death <b>1 month</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M.D.		29c. License number <b>944629</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>Nov. 6, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>San W. Klian, M.D. 600 N. Wolfe St. Baltimore, MD</b>		31. Date filed (Month, Day, Year) <b>NOV 08 2000</b>		32. Registrar's Signature 			
	33. State Registrar <b>State Registrar</b>									

ORIGINAL



Alyce Houck

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38232

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alyce Elizabeth HOUCK

2. Date of Death

Month Day Year  
November 8, 2000

3. Time of Death

8:45a.m.

4a. Facility Name (If not institution, give street and number)

Glade Valley Nursing Home

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

5. Social Security Number

220-46-5425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 13 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17512 York Road

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

William C. Geesey

18. Mother's Name (First, Middle, Maiden Surname)

Mammie Bowers

19a. Informant's Name/Relationship (Type, Print)

Robert W. Heffner - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 E. 7th Street Frederick, Maryland 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

11/10/00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. RECURRENT CEREBRAL VASCULAR ACCIDENT HOURS

Due to (or as a consequence of):

b. ARTERIO SCLEROSIS YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ADVANCED DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

826499

29d. Date signed (Month, Day, Year)

11-9-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald E. Miller, M. D. 4 Culwell Dr., Mt. Airy, Md. 21771

State  
Registrar

31. Data filed (Month, Day, Year)

NOV 16 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38233

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gary Wayne Hurst</i>					2. Date of Death Month Day Year <i>November 14, 2000</i>		3. Time of Death <i>2:50 P.M.</i>		
	4a. Facility Name (If not institution, give street and number) <i>11614 Wilhide Rd.</i>					4b. City, Town, or Location of Death <i>Thurmont</i>		4c. County of Death <i>Frederick</i>		
Funeral Director	5. Social Security Number <i>213-40-4761</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 26, 1944</i>		9. Birthplace (State or Foreign Country) <i>North Carolina</i>	
	Usual Residence of Decedent									
10a. State <i>Md.</i>		10b. County <i>Frederick</i>		10c. City, Town or Location <i>Thurmont</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>11614 Wilhide Rd.</i>					10f. Zip Code <i>21788</i>		10g. Citizen of What Country? <i>U.S.A</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Instructor</i>			16b. Kind of Business/Industry <i>Driving School</i>			
17. Father's Name (First, Middle, Last) <i>Hansel Hurst</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Nellie Unknown</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Nancy Saylor (Wife)</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11614 Wilhide Rd. Thurmont, Md. 21788</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Olivet Cemetery</i>			Date <i>Nov. 17 2000</i>		20c. Location - City or Town, State <i>Frederick, Md.</i>		
21. Signature of Funeral Service Licensee <i>Dennis L. Davis</i>					22. Name and Address of Facility <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Esophageal Cancer</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>									Approximate Interval Between Onset and Death <i>7 mo</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary artery disease</i>							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <i>D0031058</i>		29d. Date signed (Month, Day, Year) <i>11/16/00</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gene F. Ashe md 10200 Coppermine Road Woodsboro, Md 21798</i>										
31. Date filed (Month, Day, Year) <i>NOV 16 2000</i>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38234

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Marshall Hillyard				2. Date of Death Month Day Year November 16, 2000		3. Time of Death 5:46 a.m.				
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington				
Funeral Director	5. Social Security Number 219-14-9511		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 3/5/1925		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD			10b. County Washington			10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1025 Bramley Dr.					10f. Zip Code 21742			10g. Citizen of What Country? U. S. A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1943 If Yes, Give Year or Dates: 1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction worker			16b. Kind of Business/Industry Private Industry			
17. Father's Name (First, Middle, Last) Benjamin Franklin Hillyard					18. Mother's Name (First, Middle, Maiden Surname) Esther E. Rice						
19a. Informant's Name/Relationship (Type, Print) Leona E. Miller / Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 Alleman Rd. Chambersburg, PA 17201						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery			Date 11/20/00		20c. Location - City or Town, State Hagerstown, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Necrotic ischemic bowel Due to (or as a consequence of): b. metastatic lung cancer Due to (or as a consequence of): c. left lower lobe lung cancer Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 72 hours 2 weeks 6 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 					29c. License number D46473		29d. Date signed (Month, Day, Year) 11/16/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hamdan, MD 363 S. Cleveland Ave.; Hagerstown MD 21740											
31. Date filed (Month, Day, Year) NOV 17 2000			32. Registrar's Signature 								

ORIGINAL

NAME: HILLYARD, RICHARD MARSHALL  
03/05/1925 75 / M

DOS: 11/05/2000

HAMDAN, HIND



H3042320733



H282684

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38235

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN MEYERS HENNESY				2. Date of Death Month Day Year November 16, 2000		3. Time of Death 10:55 pm	
	4e. Facility Name (If not institution, give street and number) 922 Armstrong Avenue				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County	
Funeral Director	5. Social Security Number 214-09-3825		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 22, 1916	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	10a. State MD	10b. County Washington		10c. City, Town or Location Hagerstown			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 922 Armstrong Avenue			10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary		16b. Kind of Business/Industry Publishing Company		
	17. Father's Name (First, Middle, Last) Louis Meyers				18. Mother's Name (First, Middle, Maiden Surname) Mary Maude Phillips			
	19a. Informant's Name/Relationship (Type, Print) Welby M. Hennesy, Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 Armstrong Avenue, Hagerstown, MD 21740			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		Date Nov. 20	20c. Location - City or Town, State Hagerstown, Maryland		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 months							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number D46473		29d. Date signed (Month, Day, Year) 11/17/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hamdan, MD 363 S. Cleveland Ave, Hagerstown MD 21740								
31. Date filed (Month, Day, Year) NOV 20 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38236

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma Irene Hamburg

2. Date of Death

Month

Day

Year

November 19, 2000

3. Time of Death

2100

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-40-2482

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 21, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

21218 Twin Springs Dr.

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Joseph Cleveland Longnecker

18. Mother's Name (First, Middle, Maiden Surname)

Laura Pound

19a. Informant's Name/Relationship (Type, Print)

Donald Eugene Hamburg (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21218 Twin Springs Dr. Smithsburg, Md. 21783

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Cemetery

Date

Nov. 22, 2000

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

12525 Bradbury Ave.  
Davis Funeral Home Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hemorrhagic cerebral vascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D0054451

29d. Date signed (Month, Day, Year)

11/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Bonham 3019 Ventige Ct. Myersville, Md. 21046

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Hamburg, Thelma  
Baltimore, Maryland 21215-0020





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38237

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOYCE ELAINE HUNT				2. Date of Death Month Day Year NOVEMBER 21 2000		3. Time of Death 2:40 AM	
	4a. Facility Name (If not institution, give street and number) 36 FAIRGROUND AVENUE				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 219-52-2053		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 5, 1947	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location HAGERSTOWN	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 36 FAIRGROUND AVENUE		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK		16b. Kind of Business/Industry RESTAURANT			
	17. Father's Name (First, Middle, Last) DALE RENO GRAMS				18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE SOPHIA SMITH			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PATRICIA A. BILLMAN/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17948 BROADFORDING ROAD, HAGERSTOWN, MARYLAND 21740			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 11/25/00 LOCUST GROVE, MARYLAND			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME		7606 Old national Pike Boonsboro, Maryland 21713			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA OF VULVA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive pulmonary disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D21457		29d. Date signed (Month, Day, Year) 11-22-2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL WAHED, MD- 12821-OAK HILL AVE. HAGERSTOWN. MD 21742		31. Date filed (Month, Day, Year) NOV 22 2000		32. Registrar's Signature [Signature]			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38238

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emily Jeanette Hopkins

2. Date of Death

Nov. 18, 2000

3. Time of Death

12:35 pm

4a. Facility Name (If not institution, give street and number)

FutureCare-Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

215-76-0150

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 25, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1536 Shipview Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Henry Q. Boughan

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

John R. Hopkins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1536 Shipview Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

Nov. 21  
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. acute myocardial infarction

Due to (or as a consequence of):

days

c. pneumonia

Due to (or as a consequence of):

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease, atrial fibrillation, dementia, renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41955

29d. Date signed (Month, Day, Year)

11-20-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Don MD 479 Jumperst Rd #304 Severna Park MD 21146

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

Beverly B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38239

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jonathan L Ifert</b>		2. Date of Death Month <b>November</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>2:45 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>701 Park Avenue</b>		4b. City, Town, or Location of Death <b>Mount Airy</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>218-16-0198</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Feb. 28, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Mount Airy</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>701 Park Avenue</b>			10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meter Reader</b>		16b. Kind of Business/Industry <b>Power Company</b>
17. Father's Name (First, Middle, Last) <b>Daniel C. Ifert</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Ridenour</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Betty G. Ifert / wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>701 Park Ave. / Mount Airy, Maryland 21771</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pine Grove Cemetery</b>		20c. Location - City or Town, State <b>11-4-00 Mount Airy, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>			22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>8 E. Ridgeville Blvd. / Mt. Airy, MD 21771</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic carcinoma of prostate</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Heart disease</b>					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Chitrachedu Naganna</i>		29c. License number <b>D18200</b>		29d. Date signed (Month, Day, Year) <b>November 3, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chitrachedu Naganna / 700-A, Poole Rd. / Westminster, Maryland 21157</b>					
31. Date filed (Month, Day, Year) <b>NOV 06 2000</b>		32. Registrar's Signature <i>Benjamin B. Sparks</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38240

Amended 10B/11-16-2000/WCHD/MAP

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ERNEST CALVIN JONES			2. Date of Death Month: November Day: 10, Year: 2000		3. Time of Death 12:47 PM	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL			4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 213-18-9391	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) December 19, 1914	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County <del>Wicomico</del> Worcester	10c. City, Town or Location Ocean City		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 13408 Sinepuxent Ave.			10f. Zip Code 21842		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>ARMY</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Motor Freight Express</b>		
	17. Father's Name (First, Middle, Last) <b>Roy Benjamin Jones</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Corrie Viola Harp</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Pauline Romanowski/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14103 Sailing Rd., Ocean City, MD 21842</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>11/10/00 Salisbury, MD</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac Arrhythmia</b> Due to (or as a consequence of): <b>b. Hypokalemia</b> Due to (or as a consequence of): <b>c. Chronic Renal failure</b> Due to (or as a consequence of): <b>d. Nephrosclerosis</b>						Approximate Interval Between Onset and Death <b>20 mins</b> <b>24 hrs</b> <b>1 yr.</b> <b>5 yrs.</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Cardiomyopathy</b> <b>Severe Peripheral Vascular Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i>			29c. License number <b>D-20050</b>		29d. Date signed (Month, Day, Year) <b>11/10/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BENITO S. CHAN 547-G Riverside Dr. Salisbury, MD 21801</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*

NOV 1 2 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38241

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHERINE MARIE JACKSON		2. Date of Death Month Day Year NOVEMBER 13, 2000		3. Time of Death 2:00 P.M.
	4a. Facility Name (If not institution, give street and number) APT. 404 800 EAST CHESTNUT STREET		4b. City, Town, or Location of Death DELMAR		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 212-01-9747	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) FEB. 15, 1914		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County WICOMICO	10c. City, Town or Location DELMAR		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 800 E. CHESTNUT ST. APT. 404		10f. Zip Code 21875		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 5		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) CHARLES ALBERT WHETSTONE		18. Mother's Name (First, Middle, Maiden Surname) ELLEN BEATRICE HOUP		
	19a. Informant's Name/Relationship (Type, Print) DELORES DAVIDSON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 MILDALE DR. SALISBURY, MARYLAND 21804		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		20c. Location - City or Town, State 11/15/00 CAMBRIDGE, MARYLAND
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility 705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MARYLAND		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 14, 2000
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) NOV 15 2000		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

*Handwritten signature*

NOV 1 9 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38242

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSICA CHLOE JAMES				2. Date of Death Month: NOV Day: 3 Year: 2000		3. Time of Death 15:00																	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY																	
Funeral Director	5. Social Security Number 377-14-4139	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) JULY 8 1914		9. Birthplace (State or Foreign Country) IL																
	Usual Residence of Decedent																							
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location POTOMAC		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
10e. Street and Number 12700 TRAVILAH ROAD				10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.																		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VICE PRESIDENT		16b. Kind of Business/Industry NATIONAL DETECTIVE AGENCY																		
17. Father's Name (First, Middle, Last) BEN THACHTER				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN)																				
19e. Informant's Name/Relationship (Type, Print) JAYE YOUNKERS/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12700 TRAVILAH RD., POTOMAC, MD 20854																				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ENDERS/SHIRLEY F.H.		Date 11/6		20c. Location - City or Town, State BERRYVILLE, VA																		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838																				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>emphysema</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 20yrs</td> </tr> <tr> <td>b.</td> <td>tobacco smoking</td> <td>Due to (or as a consequence of):</td> <td>60yrs</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	emphysema	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 20yrs	b.	tobacco smoking	Due to (or as a consequence of):	60yrs	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	emphysema	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 20yrs																				
	b.	tobacco smoking	Due to (or as a consequence of):	60yrs																				
	c.		Due to (or as a consequence of):																					
	d.		Due to (or as a consequence of):																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Alan R. Pollack MD																						
		29c. License number D33443		29d. Date signed (Month, Day, Year) November 3, 2000																				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Pollack MD 809 Viers Mill Rd Rockville MD 20851																								
31. Date filed (Month, Day, Year) NOV 08 2000		32. Registrar's Signature B. Spotts																						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38243

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Minno Virginia Jones</b>				2. Date of Death Month Day Year <b>November 4, 2000</b>		3. Time of Death <b>10:53 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>233-40-9958</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 27, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>W. Va.</b>		10b. County <b>Jefferson</b>		10c. City, Town or Location <b>Bolivar</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>Gilbert Street</b>		10f. Zip Code <b>25425</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Service</b>				16b. Kind of Business/Industry <b>Race Track</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Charles William Staubs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Mae Snyder</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Larry W. Jones Sr. - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4813 Old Middletown Road - Jefferson, MD 21755</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Lutheran Cem.</b>		20c. Location - City or Town, State <b>11/7/00 Bolivar, W. Va.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Eackles-Spencer Funeral Home Harpers Ferry, WV 25425</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. AORTIC STENOSIS</b> Due to (or as a consequence of): <b>b. Congestive Heart Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>1997</b> <b>1997</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)						29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier 				29c. License number <b>027544</b>		29d. Date signed (Month, Day, Year) <b>11/5/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John A. Vitarello, M. D. - 180 Thomas Johnson Drive - Frederick, MD 21701</b>							
	31. Date filed (Month, Day, Year) <b>NOV 06 2000</b>				32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38244

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH JACKSON		2. Date of Death Month Day Year NOVEMBER 12, 2000		3. Time of Death 1:25 am
	4a. Facility Name (If not institution, give street and number) MILLENNIUM HEALTH & REHAB. @ S. RIVER EDGEWATER		4b. City, Town, or Location of Death ANNE ARUNDEL		4c. County of Death
Funeral Director	5. Social Security Number 219-30-6221	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) NOV. 24 1919	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 401 OAKLAWN AVENUE		10f. Zip Code 21401		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 0		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE		16b. Kind of Business/Industry ANNE ARUNDEL COMMUNITY COLLEGE		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JOHN JACKSON		18. Mother's Name (First, Middle, Maiden Surname) NANNIE ENNIS		
	19a. Informant's Name/Relationship (Type, Print) CYNTHIA BROWN (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 ANNAPOLIS ST. ANNAPOLIS, MD. 21401		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		20c. Location - City or Town, State 11/16/00 ANNAPOLIS, MD.
	21. Signature of Funeral Service Licensee Larry H. Reese M00483		22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S SYNDROME Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD NIDDM HYPERTENSION					
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND F. CAPRANO, MD 1834 GREEN TREE RD BALTO - MD - 21201				
	31. Date filed (Month, Day, Year) NOV 16 2000				
	32. Registrar's Signature Benita B. Smith				

ORIGINAL

2000 10 10 1000 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 29D 11/20/00 cmh AACO  
PER PHY.State of Maryland / Department of Health and Mental Hygiene  
HEALTH DEPT  
Certificate of Death

Reg. No.

00 38245

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Michael Judge</b>				2. Date of Death Month <b>Nov.</b> Day <b>13,</b> Year <b>2000</b>				3. Time of Death <b>8:00 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Nursing Home Spa Creek</b>				4b. City, Town, or Location of Death <b>Annapolis</b>				4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>578-26-4179</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sep 8, 1912</b>		9. Birthplace (State or Foreign Country) <b>Montana</b>		
	10a. State <b>MD</b>				10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>605 Beach Drive</b>				10f. Zip Code <b>21403</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attorney Legislative Analyst</b>				16b. Kind of Business/Industry <b>Government Analysis</b>			
17. Father's Name (First, Middle, Last) <b>Thomas Judge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jane Towey</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Suzanne Judge/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>605 Beach Drive, Annapolis, MD 21403</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>				Date <b>Nov. 16 2000</b>		20c. Location - City or Town, State <b>Davidsonville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Myocardial infarction</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>1 day</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. License number <b>D32056</b>				29d. Date signed (Month, Day, Year) <b>11/13/00</b>			
29c. Signature and title of certifier 											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gary J. Sproule 2108 P. Donald Drive Chester MD 21619</b>											
31. Date filed (Month, Day, Year) <b>NOV 20 2000</b>				32. Registrar's Signature 							

Handwritten signature or mark

NOV 8 1966



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38246

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Wilma J Keadle</u>				2. Date of Death Month <u>11</u> Day <u>19</u> Year <u>00</u>		3. Time of Death <u>1337</u>	
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>BALTIMORE CITY</u>	
Funeral Director	5. Social Security Number <u>214-28-6153</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>69</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>SEPT. 20, 1931</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
	Usual Residence of Decedent				10a. State <u>MARYLAND</u>		10b. County <u>WASHINGTON</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>BOONSBORO</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <u>111 DELLA LANE</u>				10f. Zip Code <u>21713</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TIME KEEPER</u>		16b. Kind of Business/Industry <u>STATE HOSPITAL</u>			
	17. Father's Name (First, Middle, Last) <u>HAROLD W. SIGLER</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>FRANCES RUTH HUTZELL</u>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>DONALD E. KEADLE/SPOUSE</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>111 DELLA LANE, BOONSBORO, MARYLAND 21713</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>BOONSBORO CEMETERY</u>		20c. Date <u>11/22/00</u>		20d. Location - City or Town, State <u>BOONSBORO, MARYLAND</u>	
	21. Signature of Funeral Service Licensee <u>Paul M. Dean</u> Paul M. Dean				22. Name and Address of Facility <u>BAST FUNERAL HOME</u> 7606 Old National Pike Boonsboro, Maryland 21713			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Coronary artery disease</u> Due to (or as a consequence of): b. <u>Cardiogenic shock</u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Paul M. Dean</u>		29c. License number <u>P 10249</u>	
					29d. Date signed (Month, Day, Year) <u>11/19/00</u>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DYLAN STEWART UNIVERSITY OF MARYLAND</u>							
31. Date filed (Month, Day, Year) <u>NOV 21 2000</u>				32. Registrar's Signature <u>Paul M. Dean</u>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



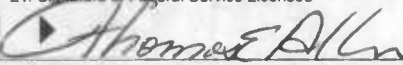

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38247

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marguerite L. Kellar</b>				2. Date of Death Month Day Year <b>Nov. 14, 2000</b>				3. Time of Death <b>8:10 am</b>				
	4a. Facility Name (If not institution, give street and number) <b>Heartlands Assisted Living</b>				4b. City, Town, or Location of Death <b>Severna Park</b>				4c. County of Death <b>Anne Arundel</b>				
Funeral Director	5. Social Security Number <b>233-62-2609</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 26, 1905</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>				
	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
10e. Street and Number <b>715 Benfield Road</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>									
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>									
17. Father's Name (First, Middle, Last) <b>William Lawson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Bogess</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Harold A. Foutty/Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2904 Greenwich Court Apt. #491 Crofton, MD 21114</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>Nov 15 2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Myocardial Infarction</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death			
		b. Due to (or as a consequence of):											
		c. Due to (or as a consequence of):											
		d. Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>assisted living facility</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>022028</b>		29d. Date signed (Month, Day, Year) <b>11 15 00</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Rhodes, MD 1667 Crofton Center Suite 1 Crofton, MD 21114</b>		31. Date filed (Month, Day, Year) <b>NOV 16 2000</b>		32. Registrar's Signature 									

1923. 51. 100.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38248

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gordon Finley Lyons						2. Date of Death Month Day Year November 13, 2000		3. Time of Death 2:37 pm	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 156-36-8387		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 23, 1949		9. Birthplace (State or Foreign Country) Scotland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 650 Heather Ridge Drive, Apt. M						10f. Zip Code 21702		10g. Citizen of What Country? United States		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1968-74		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator				16b. Kind of Business/Industry Police Department		
17. Father's Name (First, Middle, Last) Manuel Lyons						18. Mother's Name (First, Middle, Maiden Surname) Johanna Barr				
19a. Informant's Name/Relationship (Type, Print) Johanna Wolfe / Mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 Taney Avenue, Apt. 616, Frederick, Maryland 21702				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.		Date Nov. 21, 2000		20c. Location - City or Town, State Owings Mill, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Uremia Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. End Stage Renal Disease Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 48 hr 1 week years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AIDS								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.				29b. Signature and title of certifier 				29c. License number D29591		
				29d. Date signed (Month, Day, Year) 11/13/2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK P. RUBIN 201 THOMAS JOHNSON DR FREDERICK MD 21702										
31. Date filed (Month, Day, Year) NOV 17 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38249

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jennings Livesay</b>				2. Date of Death Month <b>November</b> Day <b>7</b> Year <b>2000</b>		3. Time of Death <b>1:15 a.m.</b>																
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>																
Funeral Director	5. Social Security Number <b>577-52-8387</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 23, 1936</b>																
	9. Birthplace (State or Foreign Country) <b>W. Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>																
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>10522 Cambridge Ct.</b>		10f. Zip Code <b>20886</b>		10g. Citizen of What Country? <b>United States</b>																
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Systems Analyst</b>		16b. Kind of Business/Industry <b>IBM</b>																		
	17. Father's Name (First, Middle, Last) <b>Aubrey J. Livesay</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kathryn E. Paxton</b>																		
	19a. Informant's Name/Relationship (Type, Print) <b>Tracy Bailey / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8712 Doves Fly Way/ Laurel, MD 20723</b>																		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		20c. Location - City or Town, State <b>11-8-00 Hagerstown, Maryland</b>																		
	21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>1621 Opossumtown Pike / Frederick, MD 21702</b>																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>7 days</b></td> </tr> <tr> <td>b. <b>ENCEPHALOPATHY</b> Due to (or as a consequence of):</td> <td><b>7 days</b></td> </tr> <tr> <td>c. <b>HEPATIC FAILURE</b> Due to (or as a consequence of):</td> <td><b>UNKNOWN</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>7 days</b>	b. <b>ENCEPHALOPATHY</b> Due to (or as a consequence of):	<b>7 days</b>	c. <b>HEPATIC FAILURE</b> Due to (or as a consequence of):	<b>UNKNOWN</b>	d.							
	Immediate Cause (Final disease or condition resulting in death)	a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>7 days</b>																				
b. <b>ENCEPHALOPATHY</b> Due to (or as a consequence of):		<b>7 days</b>																					
c. <b>HEPATIC FAILURE</b> Due to (or as a consequence of):		<b>UNKNOWN</b>																					
d.																							
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>cong. heart failure 2° to ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</b> <b>PNEUMONIA</b></td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>cong. heart failure 2° to ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</b> <b>PNEUMONIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>cong. heart failure 2° to ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</b> <b>PNEUMONIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																							
29b. Signature and title of certifier <i>George I. Smith, M.D. VPHM</i>				29c. License number <b>D10587</b>		29d. Date signed (Month, Day, Year) <b>11/08/2000</b>																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE I. SMITH, M.D. VICE-PRES MEDICAL AFFAIRS</b> <b>FREDERICK MEMORIAL HOSP</b> <b>FREDERICK, MD; 21701</b>																							
31. Date filed (Month, Day, Year) <b>NOV 08 2000</b>		32. Registrar's Signature <i>[Signature]</i>																					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38250

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter E. League				2. Date of Death Month Day Year Nov. 18, 2000				3. Time of Death 5:25 pm		
	4a. Facility Name (If not institution, give street and number) FutureCare-Chesapeake				4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 220-05-2863		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) May 1, 1920		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State DE		10b. County Sussex		10c. City, Town or Location Millsboro				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number RR3, Box 269A				10f. Zip Code 19966				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist				16b. Kind of Business/Industry Manufacturing			
17. Father's Name (First, Middle, Last) Charles W. League				18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Fohs							
19a. Informant's Name/Relationship (Type, Print) Betty League/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 987 Shore Acres Road, Arnold, MD 21012							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Nov 21, 2000 Baltimore, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. Cerebrovascular accident Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death days weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D-50725				29d. Date signed (Month, Day, Year) 11/20/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 479 Jennifer Riedinger MD 479 Jumpers Hole Rd Severna Park MD 21146											
31. Date filed (Month, Day, Year) NOV 21 2000		32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38251

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine Elizabeth Lowman				2. Date of Death Month Day Year November 12, 2000		3. Time of Death 5:20 p.m.		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 220-16-5042		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) January 4, 1916		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		
Usual Residence of Decedent									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
10e. Street and Number 215 S. Cherry Grove Ave.									
10f. Zip Code 21401									
10g. Citizen of What Country? U.S.A.									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Co-Owner			16b. Kind of Business/Industry Meat Market			
17. Father's Name (First, Middle, Last) Robert G. Middleton									
18. Mother's Name (First, Middle, Maiden Surname) Blanche King									
19a. Informant's Name/Relationship (Type, Print) Deborah Lomax/daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 S. Cherry Grove Ave. Annapolis, MD 21401				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens			20c. Location - City or Town, State Annapolis, MD		20d. Date 11/16/00	
21. Signature of Funeral Service Licensee Todd E. Liller					22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): a. Pneumonia b. Sepsis c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) M			28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Robert Greenfield									
29c. License number A 26373									
29d. Date signed (Month, Day, Year) 11/13/2000									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT GREENFIELD 139 OLD SOLOMONS ROAD PAROLE, MD									
31. Date filed (Month, Day, Year) NOV 16 2000									
32. Registrar's Signature [Signature]									

ORIGINAL

*[Handwritten signature]*

NOV 1 8 1960



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38252

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Wesley Logan				2. Date of Death November 14, 2000				3. Time of Death 10:30 a.m.		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 579-52-7606		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 7/31/1920		9. Birthplace (State or Foreign Country) Panama Canal		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 504 Sara Drive				10f. Zip Code 21401				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1965		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commander				16b. Kind of Business/Industry U.S. Navy			
17. Father's Name (First, Middle, Last) Joseph Calvin Arnold				18. Mother's Name (First, Middle, Maiden Surname) Marion Frantz							
19a. Informant's Name/Relationship (Type, Print) Elizabeth Lee Logan (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Sara Drive Annapolis, MD 21401							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 11/15/00		20c. Location - City or Town, State Alexandria, VA					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. coronary heart disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 10 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease hypertension								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Elaine Arata (MD)				29c. License number 045297		29d. Date signed (Month, Day, Year) 11-15-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Elaine Arata 104 Ridgely Ave Annapolis, MD 21401											
31. Date filed (Month, Day, Year) NOV 16 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene 00 38253

### Certificate of Death

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505-6100.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)  
JAMES W. LILLY

2. Date of Death  
Month: November, Day: 09, Year: 2000, Time of Death: 05:52 A.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)  
North Arundel Hospital

4b. City, Town, or Location of Death  
Glen Burnie

4c. County of Death  
Anne Arundel

5. Social Security Number  
222-62-6935

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
19 Yrs.

8. Date of Birth (Month, Day, Year)  
MARCH 3 1981

9. Birthplace (State or Foreign Country)  
DELAWARE

10a. State  
MARYLAND

10b. County  
ANNE ARUNDEL

10c. City, Town or Location  
CROFTON

10d. Inside City Limits  
☒ Yes 2 ☐ No

10e. Street and Number  
1225 MARTHA GREENLEAF DRIVE

10f. Zip Code  
21114

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12): 12th  
College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
LABORER

16b. Kind of Business/Industry  
PIPELINE

17. Father's Name (First, Middle, Last)  
FRED LILLY

18. Mother's Name (First, Middle, Maiden Surname)  
VALERIA MADDOX

19a. Informant's Name/Relationship (Type, Print)  
VALERIA LILLY (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
1225 MARTHA GREENLEAF DR. CROFTON, MD. 21114

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
METRO CREMATORY

20c. Location - City or Town, State  
11/15/00 BALTIMORE, MD.

21. Signature of Funeral Service Licensee  
Larry D. Reese M0883

22. Name and Address of Facility  
WM. REESE & SONS MORTUARY, P.A.  
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death): Multiple Injuries  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death  
1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)  
11/9/00

28b. Time of Injury  
0 25 PM

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred  
subject driven vehicle struck fire hydrant

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
Furnace Branch road and Thonon Road Anne Arundel County Maryland

29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
Theodore H. King

29c. License number  
O.C.M.E.

29d. Date signed (Month, Day, Year)  
November 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
THEODORE H. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)  
NOV 15 2000

32. Registrar's Signature  
[Signature]

NOV 1 2 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38254

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sheridan B. Miller				2. Date of Death Month: Nov Day: 05 Year: 2000		3. Time of Death 1632	
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 215-74-2774		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) April 22, 1963	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9026 Poplar Rd.		10f. Zip Code 21811		10g. Citizen of What Country? U.S.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet installer		16b. Kind of Business/Industry Furniture Retail		17. Father's Name (First, Middle, Last) William Miller	
	18. Mother's Name (First, Middle, Maiden Surname) Quinn Davis		19a. Informant's Name/Relationship (Type, Print) Quinn Davis Miller/mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9026 Poplar Rd., Berlin, MD 21811		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) New Bethel UMC Cemetery		20c. Location - City or Town, State Berlin, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Colon CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number D0053612		29d. Date signed (Month, Day, Year) 11/9/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Hoffman-Baier, 124 N. Main St., Berlin, MD 21811	
	31. Date filed (Month, Day, Year) NOV 15 2000		32. Registrar's Signature 		33. State Registrar State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

ORIGINAL

Handwritten signature or initials.

NOV 12 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38255

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH RAYNER MYERS</b>				2. Date of Death Month Day Year <b>NOVEMBER 14, 2000</b>		3. Time of Death <b>9:03 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>GLADE VALLEY NURSING &amp; REHABILITATION CTR.</b>				4b. City, Town, or Location of Death <b>WALKERSVILLE</b>		4c. County of Death <b>FREDERICK</b>	
Funeral Director	5. Social Security Number <b>213-18-7848</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 5, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD.</b>		10a. State <b>MD</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>TANEYTOWN</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>4580 FRANCIS SCOTT KEY HWY.</b>		10f. Zip Code <b>21787</b>		10g. Citizen of What Country? <b>U. S. A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ESTIMATING CLERK</b>		16b. Kind of Business/Industry <b>SHIP BUILDING</b>				
17. Father's Name (First, Middle, Last) <b>RAYNER MYERS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES FRAZIER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARY MYERS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4580 FRANCIS SCOTT KEY HWY., TANEYTOWN, MD. 21787</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NEW ST. JOSEPH'S</b>		20c. Location - City or Town, State <b>EMMITSBURG, MD. 21727</b>		20d. Date <b>11/17/2000</b>		
21. Signature of Funeral Service Licensee <i>John M. Skiles</i>				22. Name and Address of Facility <b>SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Bladder Carcinoma</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death <b>2 yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>Allen J. Gelson</i>				29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>NOV 15 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen J. Gelson MD 1475 TANEY AVE FREDERICK MD 21702</b>								
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38256

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES P. MAY				2. Date of Death Month Day Year November 15, 2000				3. Time of Death 9:00 AM	
	4a. Facility Name (If not institution, give street and number) 1701 Spring House Court				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-62-3505		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 7, 1954		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 1701 Spring House Court		10f. Zip Code 21702		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman				16b. Kind of Business/Industry Automobile	
	17. Father's Name (First, Middle, Last) George Elden May, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Gretchen Schuoler					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) June C. May / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Spring House Court, Frederick, Maryland 21702					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Date Nov. 19 2000		20d. Location - City or Town, State Hagerstown, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) A.S.C.V.D. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death Years.					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D35164		29d. Date signed (Month, Day, Year) November 16, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick Jr., MD 1080 W. Patrick St Frederick, MD 21703									
State Registrar	31. Date filed (Month, Day, Year) NOV 17 2000		32. Registrar's Signature 							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38257

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Catherine MIDDLEKAUFF

2. Date of Death

November 18 2000

3. Time of Death

7.35am

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-74-0432

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 17, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 South Walnut Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0-7

College (14 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

John T. Shank

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Hawbaker

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary Weaver - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16012 Mount Tabor Road, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Salem Reformed Church

Date

Nov.  
22, 2000

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Fred E. ...

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Bowel Disease

Due to (or as a consequence of):

unknown

c. Atherosclerosis

Due to (or as a consequence of):

years

d. Senility

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Arthritis

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Zafar Malik MD

29c. License number

D44996

29d. Date signed (Month, Day, Year)

November 18, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR. Zafar Malik 20311 Lappans RD, Boonsboro MD 21713 3014324010

31. Date filed (Month, Day, Year)

NOV 20 2000

32. Registrar's Signature

Benjamin Sparks

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38258

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH A. MATTERA

2. Date of Death

Month Day Year  
NOV. 11 2000

3. Time of Death

7:15 pm

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-42-7418

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MAY 15 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

LOTHIAN

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

151 KONRAD MORGAN WAY

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

TILE SETTER

16b. Kind of Business/Industry

J.B.G. COMPANY

17. Father's Name (First, Middle, Last)

VINCENT L. MATTERA

18. Mother's Name (First, Middle, Maiden Surname)

THERESA E. MENNA

19a. Informant's Name/Relationship (Type, Print)

MARIE STIDHAM (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22060  
9184 RICHMOND HWY. APT. B214 FT. BELVOIR, VA.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. OLIVET CEMETERY 11/17/00 WASHINGTON, D.C.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry H. Reese M00483

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. EMPHYSEMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D39037

29d. Date signed (Month, Day, Year)

11-12-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS S MITCHELL

AAMC ANNAPOLIS MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 16 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38259

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carroll Irving Nicholson</b>				2. Date of Death Month <b>November</b> Day <b>12</b> Year <b>2000</b>		3. Time of Death <b>6:52 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-28-6213</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 23, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number <b>200 East 16th Street</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> Collage (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farm Worker</b>		16b. Kind of Business/Industry <b>Farming</b>			
	17. Father's Name (First, Middle, Last) <b>Clifford N. Nicholson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Lee Riggs</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Dora Virginia See - Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14221 Hi-Wood Drive, Rockville, Maryland 20850</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Oak Cemetery</b>		Date <b>11/15/00</b>		20c. Location - City or Town, State <b>Gaithersburg, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home</b> <b>26401 Ridge Road, Damascus, Maryland 20872-0117</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Acute Myocardial Infarction</b> Minutes Due to (or as a consequence of):  b. <b>Hypertensive Cardiovascular Disease</b> Years Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D266499</b>		29d. Date signed (Month, Day, Year) <b>November 14, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald E. Miller, M.D. 4 Culwell Drive, Mount Airy, Maryland 21771</b>							
31. Date filed (Month, Day, Year) <b>NOV 16 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38260

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Brett Alexander Norris</b>				2. Date of Death Month Day Year <b>NOVEMBER 12, 2000</b>		3. Time of Death <b>11:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>20209 ROBINWOOD COURT</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>WASHINGTON</b>	
5. Social Security Number <b>212-78-0777</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>26</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 9, 1973</b>	
9. Birthplace (State or Foreign Country) <b>VA.</b>		10a. State <b>MD.</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Middletown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7386 Freestate Dr.</b>		10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>body and fender repair</b>		16b. Kind of Business/Industry <b>auto</b>		17. Father's Name (First, Middle, Last) <b>Gregory Darnell Norris</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Judith Villars</b>		19. Informant's Name/Relationship (Type, Print) <b>Gregory D. Norris (Father)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7386 Freestate Dr., Middletown, MD. 21769</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Reformed Cemetery</b>		20c. Date <b>11/16</b>		20d. Location - City or Town, State <b>Middletown, MD.</b>		21. Signature of Funeral Service Licensee 	
22. Name and Address of Facility <b>Donald B. Thompson Funeral Home</b> <b>31 E. Main St., Middletown, MD. 21769</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. METHADONE INTOXICATION</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) <b>found: 11/12/00</b>		28b. Time of Injury <b>found: 11:00 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found: residence</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>20209 Robinwood Court Hagerstown, Maryland</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 13, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>NOV 16 2000</b>	
32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

per m.l. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38261

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Gabrielle Nicholas				2. Date of Death Month Day Year November 13, 2000				3. Time of Death 4:50 P.M.			
	4a. Facility Name (If not institution, give street and number) Heritage Harbour Health & Rehab. Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 219-82-4333		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) June 2, 1961		9. Birthplace (State or Foreign Country) Louisiana			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1003 Boom Court				10f. Zip Code 21401				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 2 yrs.				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled				16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) Edward J. O'Malley				18. Mother's Name (First, Middle, Maiden Surname) Violet Frances Taylor							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Violet F. O'Malley/ Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Boom Court Annapolis, Maryland 21401							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Meml. Gardens		20c. Location - City or Town, State 11-16-00 Davidsonville, MD							
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>multiple sclerosis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death YRS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D41978		29d. Date signed (Month, Day, Year) 11-13-2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Tanakou MD 1 Hosp Dr Chen MD. 20785												
31. Date filed (Month, Day, Year) NOV 16 2000		32. Registrar's Signature 										

*Handwritten signature*

NOV 1 2 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38262

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frederick Carl NOEL

2. Date of Death

Nov. 14 00

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

10135 Garis Shop Road

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

186-28-5329

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 7, 1937

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

10135 Garis Shop Road

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

self-employed barber

16b. Kind of Business/Industry

barber shop

17. Father's Name (First, Middle, Last)

Marshall J. Noel

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy E. Barnhart

19a. Informant's Name/Relationship (Type, Print)

Helen L. Noel - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10135 Garis Shop Road, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

11-18-00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Minnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Small Cell Lung Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. McCormack M.D.

29c. License number

D 41667

29d. Date signed (Month, Day, Year)

11-16-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. McCormack 11110 Medical Campus Hagerstown, MD 21742

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 17 2000

32. Registrar's Signature

B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38263

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James Oyler</i>				2. Date of Death Month <i>November</i> Day <i>13</i> Year <i>2000</i>				3. Time of Death <i>545pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>552-68-2182</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>April 21, 1948</i>		9. Birthplace (State or Foreign Country) <i>Oregon</i>		
	10a. State <i>Maryland</i>		10b. County <i>Washington</i>		10c. City, Town or Location <i>Hagerstown</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <i>1032 Brinker Dr., Apt. 202</i>		10f. Zip Code <i>21740</i>		10g. Citizen of What Country? <i>USA</i>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1968-70</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>white</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>technician</i>		16b. Kind of Business/Industry <i>service department retail store</i>							
17. Father's Name (First, Middle, Last) <i>James Oyler</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hattie Goforth</i>							
19a. Informant's Name/Relationship (Type, Print) <i>Beverly A. Oyler - wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1032 Brinker Dr., Apt. 205, Hagerstown, Md. 21740</i>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hagerstown Crematory</i>		20c. Date <i>11-17-00</i>		20d. Location - City or Town, State <i>Hagerstown, Maryland</i>					
21. Signature of Funeral Service Licensee <i>James L. Spier</i>				22. Name and Address of Facility <i>MINNICH FUNERAL HOME</i> <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>hypoxia</i> Due to (or as a consequence of): b. <i>Aspiration Pneumonia</i> Due to (or as a consequence of): c. <i>Respiratory failure</i> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>End Stage Renal Disease</i> <i>Diabetes</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>M</i>		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature] MD</i>		29c. License number <i>12350</i>		29d. Date signed (Month, Day, Year) <i>November 15, 2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Vinial Shah, 22 South Greene Street, Baltimore, Md 21201</i>		31. Date filed (Month, Day, Year) <i>NOV 17 2000</i>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38264

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ZANE LEON OBERHOLZER, SR				2. Date of Death Month Day Year November 11, 2000		3. Time of Death 1200	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 175-40-3573		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Aug 30, 1948	
	9. Birthplace (State or Foreign Country) Waynesboro, PA		10a. State PA		10b. County Franklin		10c. City, Town or Location Waynesboro	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 9231 Anthony Highway		10f. Zip Code 17268	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1966/1972	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer				16b. Kind of Business/Industry Newspaper Company			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Raymond C. Oberholzer				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Anna Grosh			
	19a. Informant's Name/Relationship (Type, Print) Sonnia K. Oberholzer Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9231 Anthony Hwy. Waynesboro PA 17268			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Valley Crematorium		20c. Location - City or Town, State Nov 16 Waynesboro PA	
	21. Signature of Funeral Service Licensee James A. Bowersox				22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 50 S Broad ST Waynesboro PA 17268			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Very Large Cerebrovascular accident</u> Due to (or as a consequence of): b. <u>Brain Herniation</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier Jamal Ali
	29c. License number D0053405		29d. Date signed (Month, Day, Year) November 11, 2000					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamal F. Ali, MD 11110 Medical Campus RD Hagerstown MD 21740							
	31. Date filed (Month, Day, Year) NOV 16 2000				32. Registrar's Signature Benjamin S. Sparks			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 8 11/22/00 AACO HEALTH CMH

## Certificate of Death

Reg. No.

00 38265

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR ETHEL O'NEAL				2. Date of Death Month Day Year NOV. 18, 2000		3. Time of Death 11:03PM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 577 01 3056	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 23, 2000		9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND ANNE ARUNDEL EDGEWATER				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 855 HOLLY AVE.				10f. Zip Code 21037		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SWITCHBOARD OPERATOR		16b. Kind of Business/Industry TELEPHONE CO.		
17. Father's Name (First, Middle, Last) JOSEPH F. GARRY				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE REILLY				
19a. Informant's Name/Relationship (Type, Print) LINDA LEA MAYS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 855 HOLLY AVE. EDGEWATER, MD. 21037				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 11-20-00		20c. Location - City or Town, State ALEXANDRIA, VA.	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. RUPTURED AORTIC ANEURYSM Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death ONE DAY
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D38445		29d. Date signed (Month, Day, Year) NOVEMBER 19, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRA WEINSTEIN M.D. 600 RIDGELY AVE. ANNAPOLIS, MD. 21401								
State Registrar		31. Date filed (Month, Day, Year) NOV 21 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 1 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38266

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

NORMAN FILMORE PEACH, SR.

2. Date of Death

Month Day Year  
NOV. 11, 2000

3. Time of Death

12:50 am

4a. Facility Name (If not institution, give street and number)

COLLEGE VIEW NURSING CENTER

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

5. Social Security Number

212-24-3362

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 17, 1927

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

202 CENTER ST.

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR FOREMAN

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ARTHUR PEACH

18. Mother's Name (First, Middle, Maiden Surname)

LIZZIE FOREMAN

19a. Informant's Name/Relationship (Type, Print)

ESTELLE PEACH (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 CENTER ST FREDERICK MD. 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW VIEW CEM. MARKET

Date

NOV. 14, 2000

20c. Location - City or Town, State

FREDERICK MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME

110 WEST SOUTH ST FREDERICK MD. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dysphagia  
Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Quadruplegia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

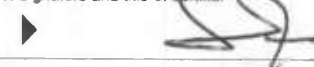
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D43091

29d. Date signed (Month, Day, Year)

11-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAEED ZAIDI MD

801 TOLL HOUSE AVE, Frederick, MD

State Registrar

31. Date filed (Month, Day, Year)

NOV 13 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38267

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM JOSEPH PUCKETT</b>			2. Date of Death Month Day Year <b>Nov. 13, 2000</b>		3. Time of Death <b>1:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>			4b. City, Town, or Location of Death <b>Salisbury, Md.</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>217-90-1484</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>32</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 2, 1968</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Quantico</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6464 Main Street</b>				10f. Zip Code <b>21856</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Wicomico County Roads</b>		16b. Kind of Business/Industry <b>County Government</b>		
17. Father's Name (First, Middle, Last) <b>Howard O. Puckett Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Ann Baker</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Howard O. Puckett Jr./Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 23, Quantico, MD 21856</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>11/15/00</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>	
21. Signature of Funeral Service Licensee <b>Keith R. Downey</b>			22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Complications of melanoma 13700 cytotoxic &lt; year</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D39813</b>		29d. Date signed (Month, Day, Year) <b>11/13/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. Atkins MD 1104 HEALTHWAY DR., SALISBURY, MD 21804</b>							
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					

WILLIAM JOSEPH PUCKETT  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

NOV 19 2000  
J. J. J. J. J.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38268

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Arthur Patterson				2. Date of Death Month Day Year November 5, 2000		3. Time of Death 10:10 PM	
	4a. Facility Name (If not institution, give street and number) 501 East Church Street				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 230-34-1986	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 7, 1931		9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 501 East Church Street				10f. Zip Code 21701		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) steamfitter		16b. Kind of Business/Industry power plants		
17. Father's Name (First, Middle, Last) James Alvin Patterson				18. Mother's Name (First, Middle, Maiden Surname) Leanna Elizabeth Austin				
19a. Informant's Name/Relationship (Type, Print) Betty Louise Patterson, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 East Church Street, Frederick, MD 21701				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee Kurt H. Burger				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier A. J. G. [Signature]				29c. License number D26516		29d. Date signed (Month, Day, Year) Nov 7 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen J. G. [Signature] 1475 TANEY AVE (FRED MD) 21702								
31. Date filed (Month, Day, Year) NOV 08 2000				32. Registrar's Signature [Signature]				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38269

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALICE JOSEPHINE PAXTON</b>		2. Date of Death Month <b>November</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>1600</b>
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>		4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>
Funeral Director	5. Social Security Number <b>508-16-8116</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 19, 1914</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>19614 Meadowbrook Road</b>		10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Artist - Architect-Interior Designer</b>		16b. Kind of Business/Industry <b>Self Employed</b>	
17. Father's Name (First, Middle, Last) <b>William Albert Rosenberger</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Adams</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Lannin Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19614 Meadowbrook Road, Hagerstown, Maryland 21742</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. Location - City or Town, State <b>11-18-2000 Hagerstown, Maryland</b>	
21. Signature of Funeral Service Licensee <b>R. Noel Brady</b>		22. Name and Address of Facility <b>Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>MINUTES</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SCORBUT</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>11-18-2000</b>		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>040622</b>		29d. Date signed (Month, Day, Year) <b>NOV 14, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BARBARA LANNIN FRIEND, 19614 MEADOWBROOK ROAD, HAGERSTOWN, MD 21742</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

NAME: PAXTON, ALICE A  
06/19/1914 86 / F

H1002355655



H233838



DOS:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38270

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Irene Alice Payton</i>				2. Date of Death Month <i>November</i> Day <i>16</i> Year <i>2000</i>				3. Time of Death <i>0945</i>	
	4a. Facility Name (If not institution, give street and number) <i>Washington County Hospital Hagerstown</i>				4b. City, Town, or Location of Death <i>Washington</i>				4c. County of Death <i>Washington</i>	
Funeral Director	5. Social Security Number <i>219-20-2187</i>		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>81</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 4, 1919</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10c. City, Town or Location <i>Hagerstown</i>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. State <i>Md.</i>		10b. County <i>Washington</i>		10f. Zip Code <i>21740</i>				10g. Citizen of What Country? <i>U.S.A</i>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>				16b. Kind of Business/Industry <i>Home</i>		
17. Father's Name (First, Middle, Last) <i>Roy C. Martz</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Stella M. Bear</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Georgia A. Ecker (Granddaughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>275 E. Catherine St. Chambersburg, Pa. 17201</i>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Smithsburg Crematory</i>		Date <i>Nov. 18, 2000</i>		20c. Location - City or Town, State <i>Smithsburg, Md.</i>		
21. Signature of Funeral Service Licensee <i>Pennis L. Davis</i>				22. Name and Address of Facility <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Pulmonary Embolus</i> Due to (or as a consequence of): b. <i>Digestive Heart Failure</i> Due to (or as a consequence of): c. <i>Coronary Artery Disease</i> Due to (or as a consequence of): d. <i></i>				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Allen Tsui MD</i>				29c. License number <i>D55072</i>		
				29d. Date signed (Month, Day, Year) <i>11/16/00</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Allen Tsui 24 N. Walnut St Hagerstown MD 21740</i>										
31. Date filed (Month, Day, Year) <i>NOV 20 2000</i>				32. Registrar's Signature <i>Beverly B Sparks</i>						

ORIGINAL

NAME: PAYTON, IRENE ALICE  
05/04/1919 81 / F

BYRKIT, MAX E.

DOS: 11/13/2000



H3042347991



H055979

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38271

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Judith Eileen Parks</b>				2. Date of Death Month <b>Nov.</b> Day <b>12,</b> Year <b>2000</b>		3. Time of Death <b>10:50 pm</b>													
	4a. Facility Name (If not institution, give street and number) <b>Crofton Convalescent Center</b>				4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>													
Funeral Director	5. Social Security Number <b>167-40-7547</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>52</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 24, 1948</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>												
	Usual Residence of Decedent																			
10e. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crofton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
10e. Street and Number <b>2131 Davidsonville Road</b>				10f. Zip Code <b>21114</b>		10g. Citizen of What Country? <b>USA</b>														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>U.S. Army</b>														
17. Father's Name (First, Middle, Last) <b>Robert McDevitt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley Horner</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Stacy Berver/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6108 Nightrose Court, Elkridge, MD 21075</b>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grandview Cemetery</b>		Date <b>Nov 16, 2000</b>		20c. Location - City or Town, State <b>Johnstown, PA</b>														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>																
23a. Part I. Enter the disease, or combination thereof that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Multiple Sclerosis</b></td> <td>Approximate Interval Between Onset and Death <b>10 years</b></td> </tr> <tr> <td>b.</td> <td><b>Dysphagia</b></td> <td><b>2 m</b></td> </tr> <tr> <td>c.</td> <td><b>Dehydration</b></td> <td><b>2 m</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Multiple Sclerosis</b>	Approximate Interval Between Onset and Death <b>10 years</b>	b.	<b>Dysphagia</b>	<b>2 m</b>	c.	<b>Dehydration</b>	<b>2 m</b>	d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Multiple Sclerosis</b>	Approximate Interval Between Onset and Death <b>10 years</b>																	
	b.	<b>Dysphagia</b>	<b>2 m</b>																	
	c.	<b>Dehydration</b>	<b>2 m</b>																	
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No														
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier 				29c. License number <b>D35848</b>		29d. Date signed (Month, Day, Year) <b>Nov. 14, 2000</b>														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Howard K. Schultz Jr. 1438 Defense Hwy Gambrills MD 21054</b>																				
State Registrar		31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 																

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural," or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
 To Be Completed by Physician/Medical Examiner

NOV 12 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38272

amend item 23a,27,28a,b,c,d,e,f per me G790 12/20/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH HUGH PERRY			2. Date of Death Month Day Year NOVEMBER 24, 2000			3. Time of Death 16:56 PM				
	4a. Facility Name (If not institution, give street and number) 1005 BAYSIDE DRIVE			4b. City, Town, or Location of Death STEVENSVILLE			4c. County of Death QUEEN ANNE'S				
Funeral Director	5. Social Security Number 215-44-6422		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 14, 1946		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD			10b. County QUEEN ANNE'S		10c. City, Town or Location STEVENSVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1005 BAYSIDE DRIVE			10f. Zip Code 21666			10g. Citizen of What Country? USA					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SANITARIAN			16b. Kind of Business/Industry ANNE ARUNDEL COUNTY					
17. Father's Name (First, Middle, Last) HUGH M. PERRY					18. Mother's Name (First, Middle, Maiden Surname) SARA MITCHELL						
19a. Informant's Name/Relationship (Type, Print) JOHN PERRY/ BROTHER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 JOHN BROWN ROAD, QUEENSTOWN, MD 21658						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESTERFIELD CEMETERY			Data 11-28-2000		20c. Location - City or Town, State CENTREVILLE, MD			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. MEPERIDINE INTOXICATION Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) found 11/24/00		28b. Time of Injury found 11:09 A M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject ingested pills		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence			28f. Location (Street and Number or Rural Route Number, City or Town, State) 1005 Bayside Drive, Stevensville, Md.								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) NOVEMBER 25, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC - 1 2000			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38273

Amended 11/15/00 #12/WCHD/MAP

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stanley Lee Robbins</b>				2. Date of Death Month: <b>Nov</b> Day: <b>10</b> Year: <b>2000</b>		3. Time of Death <b>10:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>20 Bramblewood Drive, Ocean Pines</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>215-44-7068</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>July 9, 1946</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>20 Bramblewood Drive</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>10th</b> College (1-4or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Construction</b>		
17. Father's Name (First, Middle, Last) <b>Lee Dorsey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Robbins</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Beatrice Bowen/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Bramblewood Drive, Berlin, MD 21811</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul's Cemetery</b>		Date <b>11/17/00</b>		20c. Location - City or Town, State <b>Berlin, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LUNG Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>2 months</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>MD</b>						
		29c. License number <b>D047676</b>		29d. Date signed (Month, Day, Year) <b>11/15/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. SHOR TOLUIMAT 9733 ARQUIT WAY DR BERLIN MD 21811</b>								
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

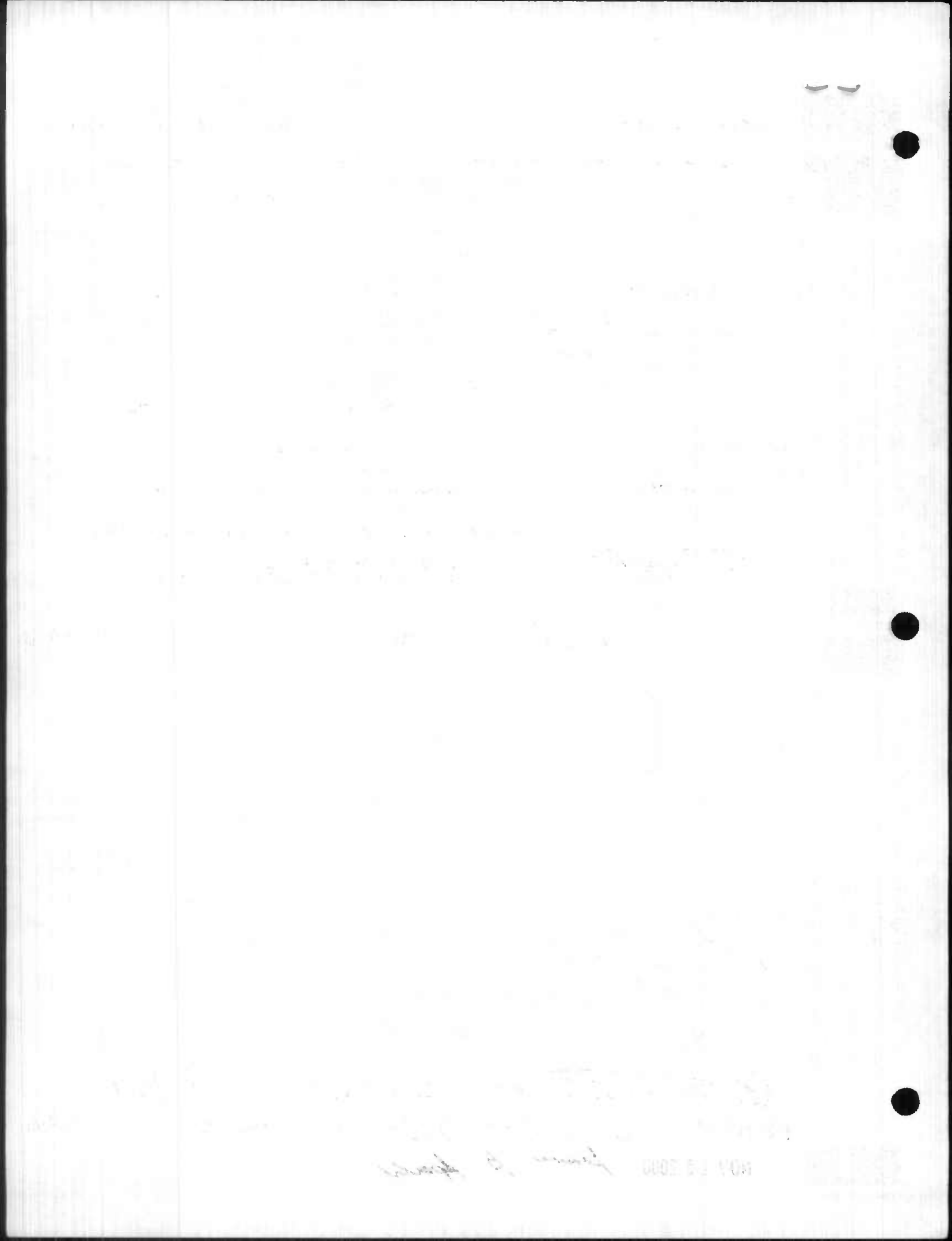
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38274

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET LINDA REILEY</b>				2. Date of Death Month Day Year <b>November 11, 2000</b>				3. Time of Death <b>4:55 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>10208 Pine Tree Road</b>				4b. City, Town, or Location of Death <b>Woodsboro</b>				4c. County of Death <b>Frederick</b>			
Funeral Director	5. Social Security Number <b>224-58-7446</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 9, 1944</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Frederick</b>		10c. City, Town or Location <b>Woodsboro</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>10208 Pine Tree Road</b>				10f. Zip Code <b>21798</b>				10g. Citizen of What Country? <b>United States</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Missionary</b>				16b. Kind of Business/Industry <b>Jehovah's Witnesses</b>			
	17. Father's Name (First, Middle, Last) <b>John Reiley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Lawson Reiley</b>							
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Margaret L. Reiley / mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10208 Pine Tree Road, Woodsboro, MD 21798</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Flint Hill Cemetery</b>				20c. Location - City or Town, State <b>11/15/00 Oakton, Virginia</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 40 Fulton Avenue, Walkersville, MD 21793</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Breast Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>2 years</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>11-13-00</b>				28b. Time of Injury <b>M</b>			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> , Attending M.D.				29c. License number <b>D30020</b>			
					29d. Date signed (Month, Day, Year) <b>11-13-00</b>							
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John A. Shutt M.D., 15 E. Freeland St, Walkersville, MD 21793-0310</b>				31. Date filed (Month, Day, Year) <b>NOV 13 2000</b>				32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38275

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Woodrow RIPPEON				2. Date of Death Month Day Year November 14 2000		3. Time of Death 11:30 AM	
	4a. Facility Name (If not Institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 212-50-9362	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 15 1948		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 13539 Wellspring Drive				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Viet-Nam		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed			16b. Kind of Business/Industry Screen Print	
17. Father's Name (First, Middle, Last) Woodrow W. Rippeon				18. Mother's Name (First, Middle, Maiden Surname) Mary E. Fritz				
19a. Informant's Name/Relationship (Type, Print) Susan L. Rippeon				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13539 Wellspring Drive Hagerstown, Md. 21740				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		Date 11/18/00		20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Bowel Obstruction Due to (or as a consequence of): b. Peritoneal Carcinomatosis Due to (or as a consequence of): c. Gastroesophageal Carcinoma Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 3 weeks 4 weeks 7 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Subacute renal failure								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Hind Hamdan, MD				29c. License number DH6473		29d. Date signed (Month, Day, Year) 11/15/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740								
31. Date filed (Month, Day, Year) NOV 16 2000				32. Registrar's Signature 				

ORIGINAL

x

alt  
alt br



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38276

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EUGENE T. ROSENBERGER</b>				2. Date of Death Month Day Year <b>NOV 19 2000</b>		3. Time of Death <b>0100</b>	
	4a. Facility Name (If not institution, give street and number) <b>9309 LAWSON LANE</b>				4b. City, Town, or Location of Death <b>LAUREL</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>173-03-3217</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 6, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Waynesboro, PA</b>		10a. State <b>PA</b>		10b. County <b>Franklin</b>		10c. City, Town or Location <b>Waynesboro</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10050 Old Forge RD</b>		10f. Zip Code <b>17268</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Confectionary Store</b>			
	17. Father's Name (First, Middle, Last) <b>Edward Rosenberger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Mentzer</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ty Rosenberger Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11269 Mentzer Gap RD Waynesboro PA 17268</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Burns Hill Cemetery</b>		20c. Location - City or Town, State <b>Nov 22 Waynesboro PA 17268</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>James A. Bowersox</b>				22. Name and Address of Facility <b>Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>LIVER CANCER</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>1 1/2 yrs</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Daughter's Home</b>				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <b>NOV 22 2000</b>				28b. Time of Injury <b>M</b>			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Roger Ingham</b>			
	29c. License number <b>105891</b>				29d. Date signed (Month, Day, Year) <b>11-20-00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Roger Ingham, MD 6510 Kenilworth Ave Riverdale MD 20737</b>				31. Date filed (Month, Day, Year) <b>NOV 22 2000</b>			
	32. Registrar's Signature <b>Roger Ingham</b>				33. Date of Death <b>NOV 19 2000</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38277

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Louise RANDALL				2. Date of Death Month Day Year November 18, 2000		3. Time of Death 12:44 p.m.	
	4a. Facility Name (If not institution, give street and number) Avalon Manor Nursing Home				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 214-09-5402		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 17, 1909	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 1214 Wabash Avenue		10f. Zip Code 21740	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) time keeper				16b. Kind of Business/Industry aircraft mfg.		17. Father's Name (First, Middle, Last) George Martin Beck	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Rena Elizabeth Green				19a. Informant's Name/Relationship (Type, Print) William Randall - son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Ridge Lane, Levittown, Pa. 19055	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		20c. Location - City or Town, State 11-21-00 Hagerstown, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Organic Brain Syndrome Due to (or as a consequence of): c. Senility Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 4 weeks years -			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Atherosclerosis				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number D44996				29d. Date signed (Month, Day, Year) November 20, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAFAR MALIK MD. 2031 LAPPANS RD BOONSBORO, MD 21713				31. Date filed (Month, Day, Year) NOV 22 2000			
	32. Registrar's Signature 							

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38278

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RHODA ANNA ROHRER

2. Date of Death

November 17, 2000

3. Time of Death

4:30 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

REEDERS MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

214-42-1118

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 6, 1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 SOUTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUS DRIVER

16b. Kind of Business/Industry

PUBLIC SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

JAMES H. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE E. GREEN

19e. Informant's Name/Relationship (Type, Print)

PATSY L. STANLEY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6541 WASHINGTON MONUMENT RD, BOONSBORO, MD 21713

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY

Date

11/20/00

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike  
Boonsboro, Maryland 21713

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. myocardial infarction  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutritiondementiapoor health

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 0055926

29d. Date signed (Month, Day, Year)

11/17/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. William Hammerash 100 Geeting Lane Keedysville, Maryland 21756/ 301-432-2222

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

State  
RegistrarNAME: Rhoda ANNA Rohrer  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38279

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Marie Stream				2. Date of Death Month Day Year November 12, 2000				3. Time of Death 5:05 p.m.		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK				4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 297-24-1910		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) NOV 22 1926		9. Birthplace (State or Foreign Country) OHIO		
	Usual Residence of Decedent										
10a. State MD		10b. County FREDERICK		10c. City, Town or Location FREDERICK				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 1726 DOGWOOD DRIVE				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKBINDER				16b. Kind of Business/Industry PRINTING			
17. Father's Name (First, Middle, Last) EDWARD MARTIN SHOVER				18. Mother's Name (First, Middle, Maiden Surname) JULIA EVVA CANNADAY							
19a. Informant's Name/Relationship (Type, Print) BONITA MORRIS/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1726 DOGWOOD DR., FREDERICK, MD 21701							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MONOCACY CEMETERY		Date 11/16		20c. Location - City or Town, State BEALLSVILLE, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HILTON FUNERAL HOME BOX 86, BARNESVILLE, MD 20838							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number MD51610				29d. Date signed (Month, Day, Year) 11-13-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Tawney Ave Suite 204, Frederick MD 21702											
31. Date filed (Month, Day, Year) NOV 16 2000		32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38280

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARRESSA STOKES</b>				2. Date of Death Month <b>November</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>11:50P</b>	
	4a. Facility Name (If not institution, give street and number) <b>Carroll County Gen Hosp</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>190 20-6067</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 10 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Alabama</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10518 Marriottville RD</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>UNKNOWN</b> College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINIST</b>		16b. Kind of Business/Industry <b>FACTORY</b>			
	17. Father's Name (First, Middle, Last) <b>JOE Wilcox</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Cook</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MAMIE Simpson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>319 Bryanstone RD BALT, MD 21136</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Erie County mem</b>		Date <b>11/13/00</b>		20c. Location - City or Town, State <b>Erie, PA</b>	
	21. Signature of Funeral Service Licensee <b>Gary L. Rollins</b>				22. Name and Address of Facility <b>GARY L Rollins F.H 110 N. South St 21701 Frederick MD</b>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>Gary L. Rollins MD</b>				29c. License number <b>D 51705</b>		29d. Date signed (Month, Day, Year) <b>11-6-00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. PANSURAYA, MD 419F Malcolm DR, Westminster MD 21157</b>							
	31. Date filed (Month, Day, Year) <b>NOV 06 2000</b>				32. Registrar's Signature <b>[Signature]</b>			
	33. Data filed (Month, Day, Year)							
	34. Registrar's Signature							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38281

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD CLIFFORD SMITH				2. Date of Death Month Day Year NOVEMBER 1, 2000				3. Time of Death 2:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-48-2427		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) Sep 23, 1948		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10e. Street and Number 5758 Sweet Bay Court				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1968-1972		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Examiner				16b. Kind of Business/Industry Social Security	
	17. Father's Name (First, Middle, Last) Clifford Edward Smith				18. Mother's Name (First, Middle, Maiden Surname) Olga Regina Sutkiewicz					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Suzanne D. Smith/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5758 Sweet Bay Court, Frederick, Maryland 21703					
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap MV Cemetery Nov 6, 2000				20c. Location - City or Town, State Flintstone, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i> M00706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>prob pulmonary embolus</i> Due to (or as a consequence of):  b. <i>hyper-coagulable</i> Due to (or as a consequence of): <i>metastatic</i>  c. <i>recurrent transitional</i> Due to (or as a consequence of):  d. <i>cell c7 bladder</i>				Approximate Interval Between Onset and Death  5 min  2 hrs  1-2 mo					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>h/o Transitional cell c7 bladder</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D146 2C	
					29d. Date signed (Month, Day, Year) Nov 1, 2000					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>UG Bausch MD 501 W 7th St Frederick MD 21701</i>									
	31. Date filed (Month, Day, Year) NOV 06 2000				32. Registrar's Signature <i>[Signature]</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38282

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Molly Sickie						2. Date of Death Month Day Year November 2, 2000		3. Time of Death 8:00 p.m.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 577-03-8547		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 20, 1907		9. Birthplace (State or Foreign Country) Russia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number 9426 Saddlebrook Court				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer			16b. Kind of Business/Industry Washington D.C.			
17. Father's Name (First, Middle, Last) Jon Goldsmith						18. Mother's Name (First, Middle, Maiden Surname) Lena Unknown				
19a. Informant's Name/Relationship (Type, Print) Joel P. Goldsmith (Nephew)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9426 Saddlebrook Court, Frederick, MD 21701				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Memorial Funeral Chapel		Date 11/05/00		20c. Location - City or Town, State West Palm Beach, FL		
21. Signature of Funeral Service Licensed						22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or torn artery. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 30 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Intracerebral Bleeding</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number D0035152		29d. Date signed (Month, Day, Year) 11-3-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.L. KRANTZ, MD 180 Thos. Johnson Dr - Frederick, MD										
31. Date filed (Month, Day, Year) NOV 06 2000		32. Registrar's Signature <u>[Signature]</u>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38283

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH TUCKER SUTTON</b>					2. Date of Death Month <b>11</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>1 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>144 West Main Street</b>					4b. City, Town, or Location of Death <b>New Market</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>577-01-5320</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>October 20, 1909</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
	10a. State <b>Maryland</b>			10b. County <b>Frederick</b>		10c. City, Town or Location <b>New Market</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>144 West Main Street</b>					10f. Zip Code <b>21774</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input type="checkbox"/>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>Department Store</b>			
	17. Father's Name (First, Middle, Last) <b>Jesse S. Tucker</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Byrd Scott</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jesse T. Sutton (Son)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>144 W. Main Street, New Market, Maryland 21774</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Paul T. Lochstampfor</b> M-00849		22. Name and Address of Facility <b>Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro, Pa. 17268</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Finest disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>W. Meyer M.D.</b>		29c. License number <b>016675</b>		29d. Date signed (Month, Day, Year) <b>11/14/00</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>WATNE AUGER, BRUNSWICK, MD.</b>									
31. Date filed (Month, Day, Year) <b>NOV 20 2000</b>		32. Registrar's Signature <b>Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38284

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Lorena Schuyler</b>		2. Date of Death Month <b>11</b> Day <b>15</b> Year <b>00</b>		3. Time of Death <b>1415</b>	
4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>159-10-2460</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Jun 13, 1908</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>	
10e. Street and Number <b>600 McKinsey Park Drive, #301</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+) <b>12</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		19. Informant's Name/Relationship (Type, Print) <b>Susan Schuyler Coile/Daughter</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Director 		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number <b>H53041</b>		29d. Date signed (Month, Day, Year) <b>11-16-00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Michael Stanzone, DO 8601 Veteran's Highway Millersville, MD</b>	
31. Date filed (Month, Day, Year) <b>NOV 21 2000</b>		32. Registrar's Signature 		33. Registrar's Name <b>Sparks</b>	





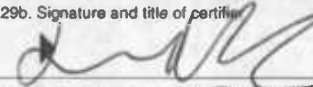
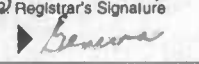
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38285

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Vance F. Rigling</b>				2. Date of Death Month Day Year <b>Nov. 17, 2000</b>		3. Time of Death <b>8:30 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>FutureCare-Chesapeake</b>				4b. City, Town, or Location of Death <b>Arnold</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>181-03-0687</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 13, 1911</b>		
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Arnold</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>571 Kevins Drive</b>		10f. Zip Code <b>21012</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Vice President</b>		16b. Kind of Business/Industry <b>Waterworks</b>		17. Father's Name (First, Middle, Last) <b>Lester B. Rigling</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Fager</b>	
19a. Intendant's Name/Relationship (Type, Print) <b>Jeff Rigling/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>571 Kevins, Drive, Arnold, MD 21012</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of): <b>Urinary tract infection</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Refractory anemia with excess blasts</b>		Approximate Interval Between Onset and Death <b>days</b> <b>days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Refractory anemia with excess blasts</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>11/18/00</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number <b>D-50725</b>		29d. Date signed (Month, Day, Year) <b>11/18/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jennifer Riedinger 479 Jumpers Hole Rd Severna Park MD 21146</b>		31. Date filed (Month, Day, Year) <b>NOV 21 2000</b>		32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38286

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mina Gorman Schoenfelder				2. Date of Death November 18, 2000				3. Time of Death 9:45 PM	
	4a. Facility Name (If not institution, give street and number) Future Care Chesapeake				4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-14-4761		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) May 16, 1921		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 572 Manor Road				10f. Zip Code 21146		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restoration Specialist			16b. Kind of Business/Industry Maryland Hall of Records		
	17. Father's Name (First, Middle, Last) Edward A. Jendrek				18. Mother's Name (First, Middle, Maiden Surname) Alcina E. Swein					
	19a. Informant's Name/Relationship (Type, Print) Mianna S. Jopp (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 572 Manor Road, Severna Park, MD 21146					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Data 11/20/00		20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee <i>Beverly M. Bartlett</i>				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester Street, Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>left upper lobe lung cancer</u> years Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>malignant left pleural effusion, chronic obstructive pulmonary disease, congestive heart failure</u>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D41955		29d. Date signed (Month, Day, Year) 11-20-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Rebecca Eron MD 479 Jumpers Hole Rd #304 Severna Park MD 21140</i>										
31. Date filed (Month, Day, Year) NOV 21 2000		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text: *Handwritten signature* 0005 1 8 VOM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38287

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James Stevens</u>				2. Date of Death Month <u>November</u> Day <u>9</u> Year <u>2000</u>				3. Time of Death <u>5:27 AM</u>		
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Systems</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>NA</u>		
Funeral Director	5. Social Security Number <u>212-32-7395</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>67</u> Yrs.		8. Date of Birth Month <u>3</u> Day <u>10</u> Year <u>1933</u>		9. Birthplace (State or Foreign Country) <u>Washington D.C.</u>		
	Usual Residence of Decedent										
10a. State <u>Maryland</u>		10b. County <u>Anne Arundel</u>		10c. City, Town or Location <u>Pasadena</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <u>8447 Lyndale Road</u>				10f. Zip Code <u>21122</u>				10g. Citizen of What Country? <u>U.S.A.</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5+</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cordinator for Field Programs</u>				16b. Kind of Business/Industry <u>MD Fire and Rescue Ins.</u>			
17. Father's Name (First, Middle, Last) <u>James G. Stevens</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Ethel Londeree</u>							
19a. Informant's Name/Relationship (Type, Print) <u>James G. Stevens III (son)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>705 Rose Creek Bluff Woodstock, GA 30189</u>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>St. Margarets Cemetery</u>		Date <u>11/12/00</u>		20c. Location - City or Town, State <u>Annapolis, MD</u>			
21. Signature of Funeral Service Licensee <u>John M. Taylor</u>				22. Name and Address of Facility <u>John M. Taylor Funeral Home</u> <u>147 Duke of Gloucester St. Annapolis, MD 21401</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Cardiac Arrhythmia</u> Due to (or as a consequence of): <u>b. Coronary Artery Disease</u> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>P. J. Alexander</u>				29c. License number <u>P14702</u>		29d. Date signed (Month, Day, Year) <u>November 9, 2000</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Pajman Alexander Danai 22 South Greene St., Baltimore, Md 21201</u>											
31. Date filed (Month, Day, Year) <u>NOV 16 2000</u>		32. Registrar's Signature <u>[Signature]</u>									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38288

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY BURTON TULL</b>				2. Date of Death Month <b>November</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>1657</b>									
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>									
Funeral Director	5. Social Security Number <b>216-18-2387</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>AUG. 4, 1923</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>									
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>7488 TITLEIST DR.</b>			10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A.</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1941</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>									
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>OIL COMPANY</b>											
	17. Father's Name (First, Middle, Last) <b>KENNETH TULL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN DOWNS</b>											
	19a. Informant's Name/Relationship (Type, Print) <b>DORIS LEE TULL - WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7488 TITLEIST DR. SALISBURY, MD 21801</b>											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERAN'S CEMETERY</b>		Date <b>11/16/00</b>		20c. Location - City or Town, State <b>HURLOCK, MARYLAND</b>									
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Coronary Heart Failure</b></td> <td>Approximate Interval Between Onset and Death <b>3 yrs</b></td> </tr> <tr> <td>b. <b>Coronary Artery Disease</b></td> <td><b>20 yrs</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Coronary Heart Failure</b>	Approximate Interval Between Onset and Death <b>3 yrs</b>	b. <b>Coronary Artery Disease</b>	<b>20 yrs</b>	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. <b>Coronary Heart Failure</b>	Approximate Interval Between Onset and Death <b>3 yrs</b>														
	b. <b>Coronary Artery Disease</b>	<b>20 yrs</b>														
	c.															
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier 				29c. License number <b>234123193</b>		29d. Date signed (Month, Day, Year) <b>11/14/00</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert J. Brander, D.O. 1201 Pemberton Dr. Salisbury MD 21801</b>																
31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 														

*[Faint, illegible handwritten text covering the majority of the page]*

NOV 12 1900  
*[Signature]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38289

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Edward Talbot				2. Date of Death Month Day Year November 08, 2000		3. Time of Death 3:47 A.M.	
	4a. Facility Name (If not institution, give street and number) R.A. Cowley Shock Trauma Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-19-3475		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 23 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 22, 1977	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Mt. Airy	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4244 Roop Road		10f. Zip Code 21771		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking				
17. Father's Name (First, Middle, Last) John Talbot				18. Mother's Name (First, Middle, Maiden Surname) Gail Purschwitz				
19a. Informant's Name/Relationship (Type, Print) Julee E. Talbot / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4244 Roop Road, Mt. Airy, Maryland 21771				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date Nov. 10, 2000		20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Head Injuries with Complications Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? Approval 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11-05-2000		28b. Time of Injury 2:45 A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred Subject was the driver of a truck which struck a tree and was ejected from truck.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) Buffalo Road north of West Falls Rd., Mt. Airy, MD				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number TM49712		29d. Date signed (Month, Day, Year) 11.9.2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maxwell WEINMANN 22 South Greene Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) NOV 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38290

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert D. Throneburg</b>				2. Date of Death Month <b>November</b> Day <b>02</b> , Year <b>2000</b>		3. Time of Death <b>4:15 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>555 Lancaster Place</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>213-30-7725</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 22, 1934</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>417 North Market Street, Apt. 1</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Realtor</b>			16b. Kind of Business/Industry <b>Real Estate</b>	
17. Father's Name (First, Middle, Last) <b>Zelotes Throneburg</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Flack</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Scott Throneburg / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10511 Tolling Clock Way, Columbia, Maryland 21044</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		Date <b>Nov. 5 2000</b>		20c. Location - City or Town, State <b>Hagerstown, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Smoke Inhalation</b> Due to (or as a consequence of): <b>b. Associated with Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>at scene</b>						
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		28a. Date of Injury (Month/Day Year) <b>Found 11-2-00</b>		28b. Time of Injury Found <b>400 A M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred <b>house fire victim</b>
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>555 Lancaster Place Frederick, MD</b>		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 02, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>NOV 06 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38291

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Leon Turner</b>				2. Date of Death Month <b>November</b> Day <b>18</b> , Year <b>2000</b>		3. Time of Death <b>9:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10910 Big Pool Road</b>				4b. City, Town, or Location of Death <b>Big Pool,</b>		4c. County of Death <b>Washington</b>	
Funeral Director	5. Social Security Number <b>215-14-2335</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 4, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Big Pool</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>10910 Big Pool Road</b>		10f. Zip Code <b>21711</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>aircraft mfg.</b>		17. Father's Name (First, Middle, Last) <b>Clarence Grant Turner</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Irene Hart</b>				19a. Informant's Name/Relationship (Type, Print) <b>Peggy Jane Moore/sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12318 Big Spring Rd. Clear Spring, MD 21722</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Shanktown Cem. Nov. 21, 2000</b>		20c. Location - City or Town, State <b>Big Pool, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald Edwin Thompson Funeral Home, Inc P.O. BOX 310 Clear Spring, MD. 21722</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Carcinoma of Prostate</b>				Approximate Interval Between Onset and Death <b>Years</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>023623</b>		29d. Date signed (Month, Day, Year) <b>Nov 20, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederic Kass 11110 Medical Campus Suite 130 Hyattstown MD.</b>				31. Date filed (Month, Day, Year) <b>NOV 20 2000</b>			
State Registrar	32. Registrar's Signature 				33. Date of Death (Month, Day, Year) <b>NOV 20 2000</b>			
	34. Date of Death (Month, Day, Year) <b>NOV 20 2000</b>				35. Date of Death (Month, Day, Year) <b>NOV 20 2000</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38292

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY B. THOMPSON</b>		2. Date of Death Month <b>November</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>7:00 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Homewood at Crumland Farms</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>578-07-2705</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 11, 1906</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Mongtomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
10e. Street and Number <b>113 Melbourne Ave.</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>	
16b. Kind of Business/Industry <b>own Home</b>		17. Father's Name (First, Middle, Last) <b>Edward E. Burch</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary S. Welch</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Edward Thompson / son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8514 Adventure Ct./ Walkersville, MD 21793</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. Location - City or Town, State <b>11-6-00 Hagerstown, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>		22. Name and Address of Facility <b>Stauffer Funeral Home 1621 Opossumtonw Pike/ Frederick, MD 21702</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Heart Disease years</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medicot examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Casper E. Cline MD</i>		29c. License number <b>D16428</b>		29d. Date signed (Month, Day, Year) <b>11/2/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Casper E. Cline, MD / 300 West Ninth St./ Frederick, MD 21701</b>					
31. Date filed (Month, Day, Year) <b>NOV 06 2000</b>		32. Registrar's Signature <i>Benjamin B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38293

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Frederick Umpleby				2. Date of Death Month Day Year November 16, 2000		3. Time of Death 4:40 A.M.		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 213-14-4879		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 18, 1921		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis		
Usual Residence of Decedent									
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
10e. Street and Number 822 Midship Court				10f. Zip Code 21401		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Electronics			
17. Father's Name (First, Middle, Last) Frank Umpleby				18. Mother's Name (First, Middle, Maiden Summa) Marie Laubert					
19a. Informant's Name/Relationship (Type, Print) Audrey D. Umpleby/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 Midship Court Annapolis, MD 21401					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. Location - City or Town, State 11-18-00 Baltimore, MD		20d. Date		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. RENAL FAILURE									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D00 44 837		29d. Date signed (Month, Day, Year) 11/16/2000			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) JOHN J KENNEDY 2003 MEDICAL PARKWAY, ANNAPOLIS MARYLAND									
31. Date filed (Month, Day, Year) NOV 17 2000				32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38294

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jessie Warren</b>				2. Date of Death Month <b>Nov</b> Day <b>8</b> Year <b>2000</b>		3. Time of Death <b>9:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Deer's Head Center</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>214-28-1998</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 16, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>GA</b>		10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Fruitland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>219 Poplar St.</b>		10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Processor</b>		16b. Kind of Business/Industry <b>Food</b>			
	17. Father's Name (First, Middle, Last) <b>Peter Johnson, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pinky Williams</b>		19a. Informant's Name/Relationship (Type, Print) <b>Elenora Warren/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>219 Poplar St., Fruitland, MD 21826</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Acres Mem Park</b>		20c. Date <b>11/13/00</b>		20d. Location - City or Town, State <b>Salisbury, MD 21801</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure</b> Due to (or as a consequence of): <b>b. pneumonia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension seizure disorder</b> <b>Recurrent stroke</b>		Approximate Interval Between Onset and Death <b>6 hours</b> <b>6 hours</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 16003</b>		29d. Date signed (Month, Day, Year) <b>11/9/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Inja J. Hwang, M.D., P.O. Box 2018, Salisbury, MD 21802-2018</b>		31. Date filed (Month, Day, Year) <b>NOV 15 2000</b>		32. Registrar's Signature 				
State Registrar								

Baltimore, Maryland 21215-0020

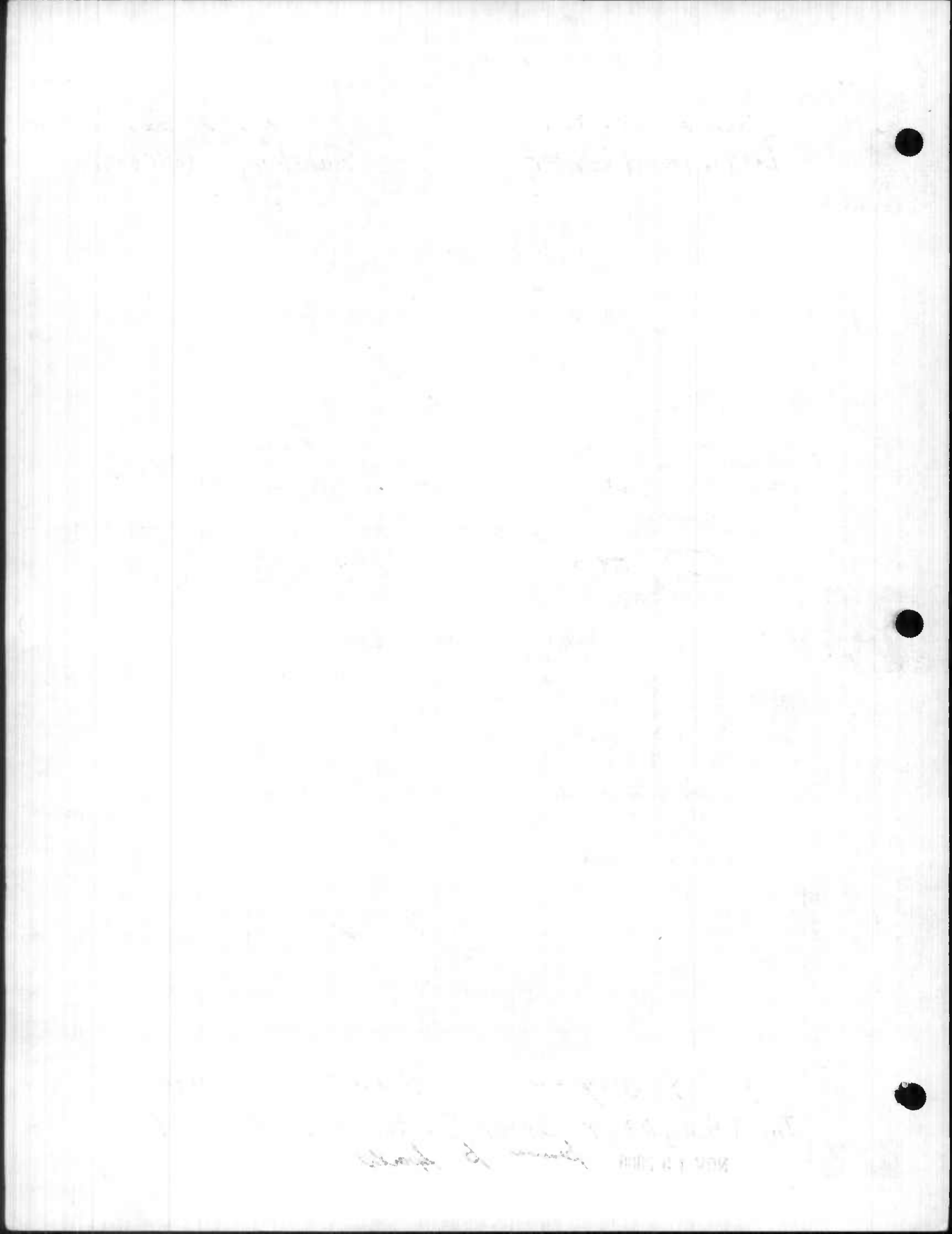
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38295

Amended item#26 FCHD 11/08/2000 KS Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Zola Marie Weaver</b>		2. Date of Death Month <b>November</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>2:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>224-24-7835</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1912</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Mount Airy</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1005 Merridale Boulevard</b>		10f. Zip Code <b>21771</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Harry Weiser</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Ford</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Gerald Johnson / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Merridale Boulevard, Mt. Airy, Maryland 21771</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wells Tannery Presbyterian Church Cemetery</b>		20c. Location - City or Town, State <b>Nov. 6, 2000 Wells Tannery, Pennsylvania</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. <b>PROBABLE ACUTE MYOCARDIAL INFARCTION</b> Minutes to Hours				
	b. <b>HYPOTENSIVE CARDIOVASCULAR DISEASE</b> YEARS				
	c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D26499</b>		29d. Date signed (Month, Day, Year) <b>11-3-00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ronald E. Miller, M.D. 4 Culwell Drive Mt. Airy, Maryland 21771</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 03 2000</b>		32. Registrar's Signature 		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38296

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Ann Wynkoop				2. Date of Death Month: November Day: 15 Year: 2000		3. Time of Death 11:13 PM																										
	4a. Facility Name (If not Institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick																										
Funeral Director	5. Social Security Number 219-20-2152		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 74 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) Nov 10 1926																										
	9. Birthplace (State or Foreign Country) Pt of Rocks MD																																
Usual Residence of Decedent																																	
10a. State MD		10b. County Frederick		10c. City, Town or Location Point of Rocks			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																										
10e. Street and Number 3701 Tuck Avenue				10f. Zip Code 21777		10g. Citizen of What Country? USA																											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Service Industry																											
17. Father's Name (First, Middle, Last) Harry J. Lambert				18. Mother's Name (First, Middle, Maiden Surname) Mary V. Heffner																													
19a. Informant's Name/Relationship (Type, Print) Bruce W. Wynkoop, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 S. Hughes Street, Hamilton, VA 20158																													
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Episcopal		Date 11/18		20c. Location - City or Town, State Point of Rocks, MD																									
21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road Brunswick MD 21716																													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Chronic obstructive pulmonary disease</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Cigarette Smoking</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td colspan="2"></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td colspan="2"></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic obstructive pulmonary disease	years	Due to (or as a consequence of):			b.	Cigarette Smoking	years	Due to (or as a consequence of):			c.				Due to (or as a consequence of):				d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic obstructive pulmonary disease	years																														
	Due to (or as a consequence of):																																
	b.	Cigarette Smoking	years																														
	Due to (or as a consequence of):																																
c.																																	
Due to (or as a consequence of):																																	
d.																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Compression fractures of T11 + L2						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																									
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kathleen W Stern MD		29c. License number D32073		29d. Date signed (Month, Day, Year) 11/16/00																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W Stern MD, 610 Ninth Ave., Brunswick, Md. 21716																																	
31. Date filed (Month, Day, Year) NOV 17 2000		32. Registrar's Signature [Signature]																															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38297

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAUL AUSTIN WILSON</b>				2. Date of Death Month Day Year <b>NOVEMBER 5, 2000</b>		3. Time of Death <b>4:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>FREDERICK</b>		4c. County of Death <b>FREDERICK</b>	
Funeral Director	5. Social Security Number <b>577-05-3717</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 30 1916</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>DICKERSON</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>856 MT. EPHRAIM RD.</b>		10f. Zip Code <b>20842</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 TH</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRONIC TECHICIAN</b>				16b. Kind of Business/Industry <b>EASTMAN KODAK COMPANY</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>THURSTON THOMAS WILSON</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>EXIE HALLMAN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>CARRIE R. WILSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>856 MT. EPHRAIM RD. DICKERSON MD. 20842</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BELLS CHAPEL CEM. NOV. 10, 2000 DICKERSON MD.</b>			
	21. Signature of Funeral Service Licensee <b>Gary L. Rollins</b>				22. Name and Address of Facility <b>GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FREDERICK, MD. 21701</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> a. <b>INCREASED INTRACRANIAL Pressure</b> Due to (or as a consequence of): b. <b>Brain hemorrhage</b> Due to (or as a consequence of): c. <b>STROKE</b> Due to (or as a consequence of): d. <b>Cardioembolism</b>				Approximate Interval Between Onset and Death <b>5 hr.</b> <b>5 hr</b> <b>12 hr</b> <b>12 hr</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL Fibrillation</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>NOV 09 2000</b>			
	28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>CTDRO MS</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D46841</b>				29d. Date signed (Month, Day, Year) <b>11/06/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>187 Thomas Johnson Drive, Frederick MD 21702</b>				31. Data filed (Month, Day, Year) <b>NOV 09 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>B Sparks</b>				33. Registrar's Name <b>B Sparks</b>			
	34. Registrar's Title <b>Registrar</b>				35. Registrar's Address <b>187 Thomas Johnson Drive, Frederick MD 21702</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38298

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margie Lee Wiles

2. Date of Death

November 3, 2000

3. Time of Death

3:10 P.M.

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

212-24-5848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 18, 1928

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Old Hagerstown Rd.

10f. Zip Code

21769

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Christian Otho Brashears

18. Mother's Name (First, Middle, Maiden Surname)

Virgie N. Lamm

19a. Informant's Name/Relationship (Type, Print)

Mary Babington (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Millrace Ln., Keedysville, MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lutheran Cemetery

Date

11/7

20c. Location - City or Town, State

Middletown, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end-stage organic brain syndrome  
pneumonia - aspiration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32518

29d. Date signed (Month, Day, Year)

11/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 14 2000

32. Registrar's Signature

ORIGINAL

Name: Margie Lee Wiles

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38299

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Ronald WALLING

2. Date of Death  
Month Day Year

November 15 2000 12:15 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-44-4466

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 10, 1946

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

846 Pine Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1973-197613. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

sheet metal worker

16b. Kind of Business/Industry

sheet metal for  
industrial use

17. Father's Name (First, Middle, Last)

Joseph George Walling

18. Mother's Name (First, Middle, Maiden Surname)

Louise Elizabeth Holmes

19a. Informant's Name/Relationship (Type, Print)

Richard Saunders - stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17810 Thornberry Rd., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

11-18-00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Coronary Heart Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Bilateral Endemic Cardiomyopathy

Due to (or as a consequence of):

c.

Arterio-sclerotic Cardiovascular Disease with

Due to (or as a consequence of):

d.

Atrial Fibrillation

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Pulmonary Chronic

Obstructive Pulmonary Disease, Atrial Fibrillation

artery embolism Cardiac Ischemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D18019

29d. Date signed (Month, Day, Year)

Nov 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Datta 334 Mill Street Hagerstown Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 17 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38300

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lewis Edward Warner, Sr.</b>				2. Date of Death Month <b>Nov</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>4:35 am</b>			
	4a. Facility Name (If not institution, give street and number) <b>606 Pasadena Road</b>				4b. City, Town, or Location of Death <b>Pasadena</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>212-30-7045</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Aug 12, 1930</b>	9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Pasadena</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>606 Pasadena Road</b>			10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>USA</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postal Worker</b>		16b. Kind of Business/Industry <b>Post Office</b>					
	17. Father's Name (First, Middle, Last) <b>Emory Z. Warner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Susan Keilhotz</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lee Warner/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>602 Pleasant View Avenue, Pasadena, MD 21122</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>Nov 20, 2000 Brooklyn, MD</b>					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Emphysema</b>										
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.									
	29b. Signature and title of certifier 				29c. License number <b>031557</b>		29d. Date signed (Month, Day, Year) <b>November 17, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Grusset, Delmar 1600 S. Craig Highway, Glen Burnie, Md. 21067</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 21 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



KENNETH AIDEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38301

AMEND#1 PER M.E. #17&19A PER INFMT. G790 12-7-2000

Reg. No.

Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth Aiden</b> KENNETH PAUL AIDEN				2. Date of Death Month Day Year November 23, 2000		3. Time of Death 1923 pm	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-82-6389	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9-28-69	9. Birthplace (State or Foreign Country) Md	
	Usual Residence of Decedent							
10a. State Md.		10b. County NA		10c. City, Town or Location Balto.			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1532 Medford Rd.				10f. Zip Code 21218		10g. Citizen of What Country? U.S.A		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12u College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Not Employed			16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) Kenneth J. Aiden				18. Mother's Name (First, Middle, Maiden Surname) Edna KANE				
19a. Informant's Name/Relationship (Type, Print) Kenneth J. Aiden FATHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1532 Medford Rd Balto md 21218				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus mem PK		Date 12/5/00	20c. Location - City or Town, State Arbutus, Md.		
21. Signature of Funeral Service Licensee Joseph G. Locks, Jr.				22. Name and Address of Facility Joseph G. Locks, Jr 3/4 13047. Central Ave				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multiple blunt force injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 11-23-2000		28b. Time of Injury 855 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred Subject struck with blunt object			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Old Town Mall					
28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore City, Maryland								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Stephen S. Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 24, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201								
State Registrar		31. Date filed (Month, Day, Year) DEC 4 2000		32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

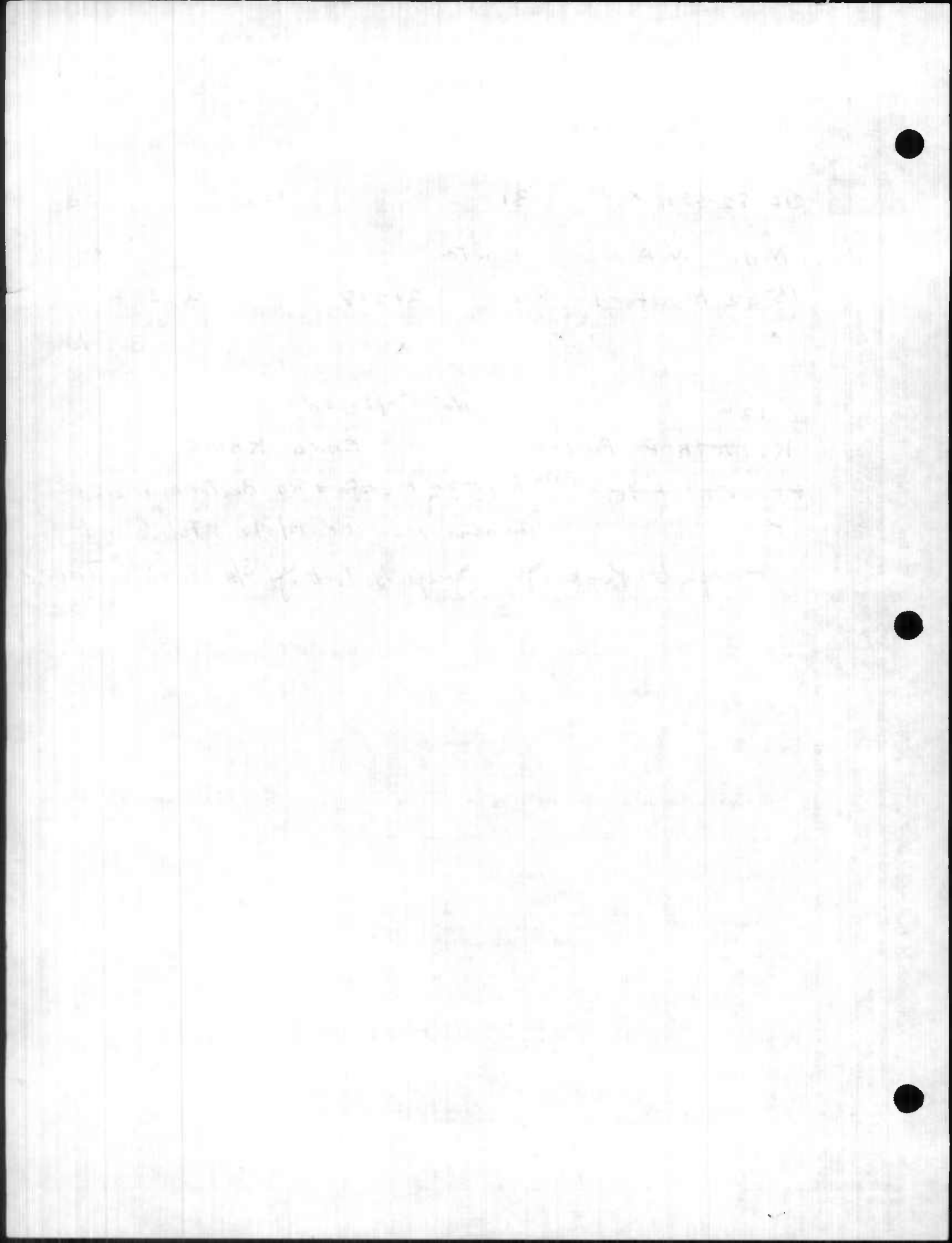
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-6000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38302

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andrew Brown</b>				2. Date of Death Month <b>November</b> Day <b>27</b> Year <b>2000</b>				3. Time of Death <b>10:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1535 North Washington Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-64-2764</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>03-16-52</b>		9. Birthplace (State or Foreign Country) <b>SC</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1500 N. Washington Street</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b>		College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>		16b. Kind of Business/Industry <b>Unemployed</b>				
17. Father's Name (First, Middle, Last) <b>Henry Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Brown</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Elijah Brown</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3107 Clifftmont Avenue Baltimore, Maryland 21213</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 12+05-2000</b>		Date <b>Lansdowne, MD</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland</b> <b>WM.C. March FH 1101 E. North Avenue 21202</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC ALCOHOLISM</b>										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 28, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chuteau</b>				<b>111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature 								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38303

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carroll Michael Bock				2. Date of Death Month Day Year Nov 29 2000				3. Time of Death 12:40 PM						
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a						
Funeral Director	5. Social Security Number 219-40-8414		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Jan 31, 1943		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 1733 West Pratt Street				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Research Manager				16b. Kind of Business/Industry Banking							
17. Father's Name (First, Middle, Last) Victor J. Bock				18. Mother's Name (First, Middle, Maiden Surname) Erma Sartoff											
19a. Informant's Name/Relationship (Type, Print) Lottie Mae Bock / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1733 West Pratt Street, Baltimore, Maryland 21223											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State 12/2/2000 Baltimore, Maryland									
21. Signature of Funeral Service Licensee Nicholas N. Velez				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Diabetes Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obesity										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Anil UBEROI MD		29c. License number D26748		29d. Date signed (Month, Day, Year) 12/11/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211															
31. Date filed (Month, Day, Year) DEC 1 2000				32. Registrar's Signature [Signature]											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38304

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosemarie Bradley

2. Date of Death

November 29 2000

3. Time of Death

4:12 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-64-2919

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3/2/46

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore,

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5127 Queenberry Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Samuel Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Nora Lee

19a. Informant's Name/Relationship (Type, Print)

Nora Lee Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5127 Queenberry Ave, Baltimore, Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

12/5/00 Lansdown, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Estep Brothers Funeral Ser, P.A.

1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Neurosarcoidosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES000

29d. Date signed (Month, Day, Year)

November 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roluando Falcon

2401 W. Belvedere, Baltimore MD 21215

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Patient known as: Bradley, Rosemarie

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38305

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Samuel V. Cimino				2. Date of Death Month Day Year December 1 2000		3. Time of Death 11:30 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 215-01-8797	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Data of Birth (Month, Day, Year) NOV. 6, 1920	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
10e. State MD		10b. County Anne Arundel		10c. City, Town or Location Pasadena		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7811 Outing Avenue				10f. Zip Code 21122		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Mechanic		16b. Kind of Business/Industry National Gypson Co.		
17. Father's Name (First, Middle, Last) (Unavailable)				18. Mother's Name (First, Middle, Maiden Surname) (Unavailable)				
19a. Informant's Name/Relationship (Type, Print) Vivian Cimino - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 Outing Avenue, Pasadena, Md. 21122				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.		20c. Location - City or Town, State Elkridge, Md.		
21. Signature of Funeral Service Licensee Moz K. Marshall				22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MASSIVE INTRACRANIAL BLEED Due to (or as a consequence of): b. LIVER CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number D43977		29d. Date signed (Month, Day, Year) December 1 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amgen Oncology 301 Hospital Drive - Glen Burnie, MD 21061.								
31. Date filed (Month, Day, Year) DEC 4 2000				32. Registrar's Signature B. Frank				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38306

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John A. Ceplickas</b>				2. Date of Death Month <b>December</b> Day <b>01</b> Year <b>2000</b>		3. Time of Death <b>6:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>197-03-5267</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 15, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Laurel</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>318 Eagel Harbor South</b>		10f. Zip Code <b>20724</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Printer</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Printer</b>		16b. Kind of Business/Industry <b>US Government Treasury Department</b>			
	17. Father's Name (First, Middle, Last) <b>Michael Ceplickas</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Tetaluta</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Beatrice Ceplickas- wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>318 Eagle Harbor South, Laurel, Maryland 20724</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. Date <b>Dec. 5, 2000</b>		20d. Location - City or Town, State <b>Elkridge, Maryland 21075</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Fleck Funeral Home 7601 Sandy Spring Road, Laurel, Maryland 20707</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Respiratory Arrest</b> Due to (or as a consequence of): b. <b>Brady Cardia</b> Due to (or as a consequence of): c. <b>Chronic obstructive pulmonary Disease</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>minutes</b> <b>minutes</b> <b>15 years</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>slp abdominal surgery for bowel perforation 11/27/00</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>		29c. License number <b>D39532</b>		29d. Date signed (Month, Day, Year) <b>12/1/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>321 Prince George St. Laurel, Md. 20707</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner



00 38307

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GERALDINE M CONNELLY</b>				2. DATE OF DEATH MONTH <b>11</b> DAY <b>28</b> YEAR <b>00</b>		3. TIME OF DEATH <b>12:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>21412 4374</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-20-19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ROCKSPRING VILLAGE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>FOREST HILL</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Forest Hill</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1 Colgate Drive</b>				10f. ZIP CODE <b>21050</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert C. Schutz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maureen Eltatt</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gregory Connelly / son</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 Mace Ave Baltimore MD 21221</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery 12/1/00</b>		20c. LOCATION — City or Town, State <b>Baltimore MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R-Terry Connelly</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. AdenocARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>one month</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mark Wild MD</b>				29c. LICENSE NUMBER <b>435522</b>		29d. DATE SIGNED (Month, Day, Year) <b>NOVEMBER 28, 2000</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARK WILD 2 NORTH AVENUE BEL AIR MARYLAND 21014</b>							
31. DATE FILED (Month, Day, Year) <b>DEC 4 2000</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38308

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ellsworth Leonard Ensey				2. Date of Death Month Day Year November 30 2000		3. Time of Death 0325	
	4a. Facility Name (If not institution, give street and number) Mercy Hospital - Stella Maris Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 218-18-6242	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 18, 1922		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3300 Benson Avenue #202				10f. Zip Code 21227		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker		16b. Kind of Business/Industry Food		
17. Father's Name (First, Middle, Last) Marion Ensey				18. Mother's Name (First, Middle, Maiden Surname) Genevieve Knapp				
19a. Informant's Name/Relationship (Type, Print) Kristen Ensey - daughter-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Chase Hill Drive, Severn, Maryland 21144				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 12/2/00		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Lung Cancer b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier David Rosenberg				29c. License number D40854		29d. Date signed (Month, Day, Year) November 30, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rosenberg 301 St Paul Pl Baltimore 21202								
31. Date filed (Month, Day, Year) DEC 4 2000		32. Registrar's Signature B. Jones						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-0050.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38309

LESTER ELLIN  
Baltimore, Maryland 21215-0036  
NOVEMBER 29, 2000  
12:58 AM

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LESTER</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>12:58AM</b>
	4a. Facility Name (If not institution, give street and number) <b>GILCHRIST CENTER - HOSPICE OF BALTIMORE</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>212-10-8159</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>
	8. Date of Birth (Month, Day, Year) <b>JAN. 11, 1917</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>11 SLADE AVENUE #207</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CERTIFIED PUBLIC ACCOUNTANT</b>		16b. Kind of Business/Industry <b>ACCOUNTING</b>		
	17. Father's Name (First, Middle, Last) <b>MORRIS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELLIN GOLDIE ROSEN</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>CAROL ELLIN / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 SLADE AVENUE #207 - BALTIMORE, MD 21208</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW CEMETERY</b>		20c. Location - City or Town, State <b>12/01/00 REISTERSTOWN, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>a. esophageal cancer</b>				<b>8 months</b>
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley G BMC 6701 N. Charles St. Balto. md 21208</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature 		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #17 PER F.H. G790 12-400 WR.

## Certificate of Death

Reg. No.

00 38310

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ABRAHAM FINKELSTEIN</b>		2. Date of Death Month Day Year <b>NOVEMBER 29, 2000</b>		3. Time of Death <b>10:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>3401 W. ROGERS AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>264-58-7654</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JUN. 6, 1918</b>		9. Birthplace (State or Foreign Country) <b>POLAND</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10a. Street and Number <b>3401 W. ROGERS AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BUTCHER</b>		16b. Kind of Business/Industry <b>MEAT</b>
	17. Father's Name (First, Middle, Last) <b>BORUCH FINKELSTEIN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>(UNKNOWN)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>CHANA FINKELSTEIN / WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3401 W. ROGERS AVENUE - BALTIMORE, MD 21215</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH JACOB CEMETERY</b>		Date <b>12/1/00</b>
	20c. Location - City or Town, State <b>FINKSBURG, MD</b>				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
Physician /Medical Examiner	23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <b>Cardiorespiratory Arrest</b> Due to (or as a consequence of):				
	b. <b>Coronary artery disease</b> Due to (or as a consequence of):				
	c. <b>Hypertensive cardiovascular disease</b> Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Overweight</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Howard B. Chen M.D.</b>		29c. License number <b>D21680</b>		29d. Date signed (Month, Day, Year) <b>11/30/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6717 Park Heights Ave - Balto, MD 21215</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38311

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronnie

Graham

2. Date of Death

November 30, 2000

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

212-58-6198

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01 12 54

9. Birthplace (State or Foreign Country)

M.D.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2525 Eutaw Place Apt 410

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

na

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Salvation Army

17. Father's Name (First, Middle, Last)

Henry Graham

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Goodman

19a. Informant's Name/Relationship (Type, Print)

Shirley Solomon-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2826 Harlem Ave, Baltimore Md 21216

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King Memorial Park

Date

12/4/00

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md 21215

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause at each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P 14577

29d. Date signed (Month, Day, Year)

11/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edgar Henriques, M.D. to Maryland General Hospital

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 04 2000

32. Registrar's Signature

ORIGINAL

Ronnie Graham  
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38312

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND EDWARD FEASTER

2. Date of Death

Month Day Year  
NOV 29, 2000

3. Time of Death

17-25

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

22 UPPER CHEESAPEAKE MED CTR

4b. City, Town, or Location of Death

BELAIR

4c. County of Death

HARFORD

5. Social Security Number

236-48-3172

6. Sex

M F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 22, 1934

9. Birthplace (State or Foreign Country)

W.V.

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

FOREST Hill

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1376 W. JARRETSVILLE RD

10f. Zip Code

21050

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8thCollege (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLARIFIER OPERATOR

16b. Kind of Business/Industry

FOOD Chain

17. Father's Name (First, Middle, Last)

SAM FEASTER

18. Mother's Name (First, Middle, Maiden Surname)

Grace KOONTZ

19a. Informant's Name/Relationship (Type, Print)

NORMA J. FEASTER (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7415 ALVAH AVE APT. B DUNDALK MD, 21222

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

12/2/00

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Paul M. Stells

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME LTD.  
7527 HARFORD RD. BALTO. MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE AIRWAY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul M. Stells

OMC

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOV 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GSPABHU MD 128 BELAIR MD BELAIR MD 21014

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38313

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) <b>PAUL P. GENTILE, SR</b>				2. Date of Death Month Day Year <b>NOV. 29, 2000</b>		3. Time of Death <b>0945 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GILCHRIST HOSPICE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-32-9017</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR. 1, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE, MD</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3006 WESTFIELD AVE</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BARBER</b>		16b. Kind of Business/Industry <b>SELF</b>		17. Father's Name (First, Middle, Last) <b>PHILLIP P. GENTILE</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES PERRERA</b>		19a. Informant's Name/Relationship (Type, Print) <b>CONCETTA GENTILE/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3006 WESTFIELD AV. BALTO MD. 21234</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>		20c. Location - City or Town, State <b>BALTO Co. MD.</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>HARTLEY MILLER FUNERAL HOME, CHD. 7527 HARFORD RD BALTO MD 21234</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Ischemic cardiomyopathy</b> Due to (or as a consequence of):		b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):		c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>renal failure</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		
29c. License number <b>D25205</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W. A. Riley GENE 6701 N. Charles St. Balto MD 21204</b>		31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		
32. Registrar's Signature <i>[Signature]</i>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38314

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ernestine Harvey</i>				2. Date of Death Month <i>November</i> Day <i>30</i> Year <i>2000</i>		3. Time of Death <i>9:35 p.m.</i>	
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>	
Funeral Director	5. Social Security Number <i>218-26-9939</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>66</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>11/10/1934</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <i>4102 Forrest Park Ave.</i>		10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic Worker</i>		16b. Kind of Business/Industry <i>Housekeeper</i>		17. Father's Name (First, Middle, Last) <i>Robert Boller</i>		
18. Mother's Name (First, Middle, Maiden Surname) <i>Thomasina Frazier</i>		19a. Informant's Name/Relationship (Type, Print) <i>Edna Scott / Sister</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3915 Calloway Ave., Baltimore, Maryland 21215 Apt. 103</i>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arbutus Memorial Pk. Cem</i>		20c. Date <i>12/05/00</i>		20d. Location - City or Town, State <i>Baltimore, Maryland</i>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		
22. Name and Address of Facility <i>Derrick C. Jones Funeral Home</i>		22b. City or Town, State, Zip Code <i>4611 Park Heights Ave., Baltimore, Maryland 21215</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pneumonia</i>		Approximate Interval Between Onset and Death		
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <i>N/A</i> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>November 30, 2000</i>		
28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Jonathan Turoff, M.D. OF THE DAY</i>		29c. License number <i>053072</i>		
29d. Date signed (Month, Day, Year) <i>November 30, 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jonathan Turoff 5601 Loch Raven Boulevard, Baltimore, MD-21239</i>		31. Date filed (Month, Day, Year) <i>DEC 4 2000</i>		32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38315

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THEODORE W HURSEY</b>				2. Date of Death Month <b>11</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>9 30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>213-34-7859</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11 24 30</b>	9. Birthplace (State or Foreign Country) <b>M.D.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>936 North Bentalou Street</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+) <b>na</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Food Corp.</b>		
17. Father's Name (First, Middle, Last) <b>Howard Hursey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Hill</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lauretta Barnes-Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>936 North Bentalou Street, Baltimore Md 21216</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>12/5/00</b>		20c. Location - City or Town, State <b>Randallstown, Md</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>				
23a. (Part I). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE RESPIRATORY DISTRESS SYNDROME</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Tara Lipani MD</i>				29c. License number <b>P14684</b>		29d. Date signed (Month, Day, Year) <b>11/30/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TARA LIPANI, MD UMMS 225. GREENE ST., BALTIMORE MD 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 04 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



SHARON  
HUGES

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38316

AMEND#7 PER F.H. G790 12-4-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sharon J. Hughes

2. Date of Death

Month Day Year  
NOVEMBER 27, 2000

3. Time of Death

9:06P.M.

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

UNK

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
June 23, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1331 Division St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self employed

16b. Kind of Business/Industry

Produce

17. Father's Name (First, Middle, Last)

Clarence Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Viola Jameson

19a. Informant's Name/Relationship (Type, Print)

Wayne Hughes - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 S. Woodington Rd. Balto. MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION Cemetery Dec 03, 2000 Balto. MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Alexander M. Coles

22. Name and Address of Facility

Tristate Funeral Service  
108 W. North Ave. Balto. MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Occlusive Pulmonary Thromboemboli

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Deep Vein Thrombosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Pestaner M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

P. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38317

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DANIEL L HOFFMAN</b>				2. Date of Death Month <b>11</b> Day <b>28</b> Year <b>2000</b>				3. Time of Death <b>8:38 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore City</b>	
Funeral Director	5. Social Security Number <b>213-20-3346</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 08 1926</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1206 West Pratt Street</b>				10f. Zip Code <b>21223</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Boiler Maker</b>				16b. Kind of Business/Industry <b>Maryland Dry Dock</b>		
17. Father's Name (First, Middle, Last) <b>Charles Richard Hoffman</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Rebecca Ingram</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Karen Sue Cumberland / friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3203 Strickland Street, Baltimore, Maryland 21229</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Olivet Cemetery</b>		Date <b>12/2/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Quanta R Thomas</b>				22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CANCER</b>										
23b. Approximate Interval Between Onset and Death <b>5 years</b>										
23c. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>P13133</b>				29d. Date signed (Month, Day, Year) <b>11/28/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS LUDWIG, 225 Greene Street, Baltimore, Maryland, 21201</b>										
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>				32. Registrar's Signature <b>James B. Spauls</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38318

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Mary Holsclaw</b>				2. Date of Death Month Day Year <b>DECEMBER 03 2000</b>				3. Time of Death <b>7:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-01-6676</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 1, 1904</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>5949 Benton Heights Avenue</b>				10f. Zip Code <b>21206</b>		
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th, Grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephone Operator</b>				16b. Kind of Business/Industry <b>U.S. Government</b>				17. Father's Name (First, Middle, Last) <b>John E. McCann</b>		
	18. Mother's Name (First, Middle, Maiden Surname) <b>Annie C. VanHorn</b>				19a. Informant's Name/Relationship (Type, Print) <b>Robert Holsclaw/ Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5949 Benton Heights Avenue Baltimore MD 21206</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Prospect Hill Cemetery</b>				20c. Location - City or Town, State <b>Towson, MD</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller, Inc. 6415 Belair Road Baltimore MD 21206</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>PULMONARY EDEMA</b> Due to (or as a consequence of): b. <b>INTRACTABLE CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): c. <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>36 hours</b> <b>36 hours</b> <b>3 DAYS</b>		
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>DR WILL MD</b>				29c. License number <b>A732438946</b>			
29d. Date signed (Month, Day, Year) <b>DECEMBER 3, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KEARY R. Williams 6906 BONNIE RIDGE Dr #101 BALTIMORE, MD 21209</b>				31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>			
32. Registrar's Signature 				33. State Registrar <b>DEC 4 2000</b>				34. Original			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



00 38319

## Reg. No.

DHHM 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician  
/Medical  
Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38320

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albert Benton James</b>						2. Date of Death Month Day Year <b>Nov. 30 2000</b>		3. Time of Death <b>10:30 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Mariner Nursing Home</b>						4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>253-12-5025</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 2 1915</b>		9. Birthplace (State or Foreign Country) <b>Tennessee</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Jessup</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>8013 Jones Road</b>				10f. Zip Code <b>20794</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW2</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>			16b. Kind of Business/Industry <b>Education System</b>				
17. Father's Name (First, Middle, Last) <b>Albert Franklin James</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Temmie Perkins</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Madelaine Lamb- Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9490 Crisscross Court, Columbia, Maryland 21045</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland National Cemetery</b>		Date <b>12/5/ 2000</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Gene Schlanger MD</b>				22. Name and Address of Facility <b>Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>										Approximate Interval Between Onset and Death <b>14 Days</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Alveda Ali Khan M.D.</b>				29c. License number <b>D43323</b>			
				29d. Date signed (Month, Day, Year) <b>Dec. 04, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ABEGA ALI KHAN 10794 Hickory Ridge Road, Columbia MD 21044</b>											
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>				32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38321

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CELESTINE JOHNSON</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>18 : 37</b>		
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital Baltimore</b>				4b. City, Town, or Location of Death		4c. County of Death		
Funeral Director	5. Social Security Number <b>218 867767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 23 1961</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1701 Darley Ave.</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>dietary Aide</b>		16b. Kind of Business/Industry <b>Food Service</b>				
	17. Father's Name (First, Middle, Last) <b>Eugene Johnson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Delores Gaskins</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Shekita Thompson-daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1701 Darley Ave. Balto. MD 21213</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		Date <b>Dec. 02 2000</b>		20c. Location - City or Town, State <b>Balto. MD</b>		
	21. Signature of Funeral Service Licensee <b>Leander M. Coles</b>				22. Name and Address of Facility <b>Tristate Funeral Service 108 W. North Ave. Balto. MD 21201</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPTICEMIA.</b> Due to (or as a consequence of): <b>SYSTEMIC LUPUS ERYTHEMATOSUS</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						Approximate Interval Between Onset and Death <b>48 hours</b> <b>10 years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>SURGEON RESIDENT</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 25 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. R. A. WATSON 600 NORTH WOLFE STREET BALTIMORE MD 21287-9106</b>									
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>B. Sparks</b>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38322

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Madeline Mabel Jackson				2. Date of Death Month Day Year Nov. 28, 2000				3. Time of Death 11:20 AM		
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing and Rehabilitation				4b. City, Town, or Location of Death Ellicott City				4c. County of Death Howard		
Funeral Director	5. Social Security Number 215-16-5241		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) June 28, 1922		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 3710 Clarenell Road				10f. Zip Code 21229				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Unknown							
19a. Informant's Name/Relationship (Type, Print) Mark M. Evans/ Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 Clarenell Road, Baltimore, Maryland 21229							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 11/29/2000		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Aspiration Pneumonia</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death 2 hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number 023365				29d. Date signed (Month, Day, Year) 11/29/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 Morden Choice Lane #205, Baltimore, MD 21228											
31. Date filed (Month, Day, Year) DEC 4 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38323

amend item 5 per fh G790 12/14/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>REGINALD KRISHER</b>				2. Date of Death Month Day Year <b>NOVEMBER 30 2000</b>		3. Time of Death <b>12 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BALTIMORE VETERAN ADMINISTRATION HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>213-30-8837</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 18 1935</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9727 Red Clover Court</b>		10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>		16b. Kind of Business/Industry <b>Bar</b>				
17. Father's Name (First, Middle, Last) <b>Charles Russell Krisher</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Isabelle Elizabeth Lanham</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rhonda Smith / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>605 South Eaton Street Baltimore Md. 21224</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc</b>		20c. Date <b>12/4/2000</b>		20d. Location - City or Town, State <b>Baltimore MD</b>		
21. Signature of Funeral Service Licensee <b>R. Terry Connolly</b>				22. Name and Address of Facility <b>Connolly Funeral Home of Essex 300 MACE AVE. Baltimore Md 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. <b>UROSEPSIS</b>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>3 DAYS</b>				
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):						
		Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>METASTATIC (TO LIVER) RECTAL CANCER</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29c. Signature and title of certifier <b>INTERNAL MED PG43</b>		29d. License number <b>P12359</b>		29e. Date signed (Month, Day, Year) <b>November 30, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TITUS ABRAHAM University of Maryland Hospital, Dept. of MEDICINE, 16 S Eutam St., Balti. 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>[Signature]</b>						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38324

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN ADAM KRAUSE</b>				2. Date of Death Month Day Year <b>November 28, 2000</b>		3. Time of Death <b>12:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>5215 EASTERN AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-05-0494</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 23, 1905</b>		
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5215 EASTERN AVE.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>TRUCKING</b>					
17. Father's Name (First, Middle, Last) <b>WALTER LADISLAUS KUJAWSKI</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA DRAPCZYNSKA</b>					
19a. Informant's Name/Relationship (Type, Print) <b>RUTH KRAUSE/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5215 EASTERN AVE. BALTIMORE, MD. 21224</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. STANISLAUS CEM.</b>		20c. Date <b>12/2/00</b>		20d. Location - City or Town, State <b>BALTIMORE, MD.</b>			
21. Signature of Funeral Service Licensee <i>Elizabeth J. Jankowski</i>		22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC.</b> <b>6224 EASTERN AVE., BALTIMORE, MD.</b>		22. Zip Code <b>21224</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CANCER OF THE PANCREAS</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. Due to (or as a consequence of):</b> <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>Carol F. Thayer MD</i>		29c. License number <b>D38033</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>L. IBARRA 261 ST. HIGHLAND AVE BALTIMORE MD 21224</b>		31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <i>James B. Spence</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38325

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oneta D. Kohler

2. Date of Death

Month Day Year  
Dec 2, 2000

3. Time of Death

9:45 p.m.

4a. Facility Name (If not institution, give street and number)

Sunrise Assisted Living of Columbia

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

120-32-6034

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jul 23, 1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

New York

10b. County

Monroe

10c. City, Town or Location

Rochester

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

64 Edgemont Rd

10f. Zip Code

14620

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Eugene J. Dye

18. Mother's Name (First, Middle, Maiden Surname)

Cora B. Austin

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert Kohler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

362 True Hickory Drive Rochester, New York 14615

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Pleasant Cemetery

Date

12/11/00

20c. Location - City or Town, State

Shelby, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Miller Funeral Home  
3325 Winton Road South Rochester, New York 14623Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease  
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50778

29d. Date signed (Month, Day, Year)

December 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Price, Michelle MD 11055 Little Patuxent Parkway Columbia, MD 21044

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



00 38326

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Margie Laverne Moore-Sedgwick

State of Maryland / Department of Health and Mental Hygiene

00 38327

amend item 23a,27,28a,bcdef per me G791 1/16/01 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGIE L. MOORE-SEDGWICK</b>				2. Date of Death Month Day Year <b>November 29, 2000</b>				3. Time of Death <b>11:35 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>312-70-2932</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG 5 1961</b>		9. Birthplace (State or Foreign Country) <b>ALABAMA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>MIDDLE RIVER</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>26 BLACKFOOT COURT</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12yrs</b> College (1-4 or 5+) <b>2yrs</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATION</b>			16b. Kind of Business/Industry <b>PDP COMPANY-Hunt Valle</b>		
	17. Father's Name (First, Middle, Last) <b>GEORGE TAYLOR</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BERNICE MOORE</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Aubrey Wm. Sedgwick/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26 Blackfoot Ct., Middle River, Md. 21220</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HOLLY HILLS MEMORIAL</b>		Date <b>12-5-00</b>		20c. Location - City or Town, State <b>MIDDLE RIVER, MARYLAND</b>			
	21. Signature of Funeral Service Licensee <i>Charles H. Powell</i>				22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S. PHILADELPHIA BLVD ABERDEEN, MD 21001</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACCELERATED GRAFT ATHEROSCLEROSIS WITH STENT THROMBOSIS a. FOLLOWING HEART TRANSPLANT COMPLICATING HEAD INJURIES</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>11/29/00</b>		28b. Time of Injury <b>10:58</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred, subject with a severe heart condition fell and struck her head	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>store</b>										
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>7735 Eastern Blvd. Baltimore, Md.</b>										
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Mary G. Ripple, M.D.</i>				29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>November 30, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38328

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EARL F McGAHA JR.				2. Date of Death Month Day Year November 25 2000				3. Time of Death 4:33 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-26-0882		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) April 24 1929		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Md		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3551 Edwards Lane				10f. Zip Code 21220				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Langenfelder		
17. Father's Name (First, Middle, Last) Earl F McGaha Sr.				18. Mother's Name (First, Middle, Maiden Surname) Gurtrude Harman						
19a. Informant's Name/Relationship (Type, Print) Phyllis McGaha /wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3551 Edwards Lane Baltimore MD. 21220						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 11/29/2000			20c. Location - City or Town, State Baltimore MD				
21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md 21221						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL INFARCTION one hour Due to (or as a consequence of): Coronary artery disease										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Diabetes Mellitus										
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier [Signature]				29c. License number D18326				29d. Date signed (Month, Day, Year) 11/26/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAEEM GAUHAH MD, ESSEX MED. CENTER, 404 Eastern Blvd Baltimore, MD. 21221										
31. Date filed (Month, Day, Year) DEC 4 2000				32. Registrar's Signature [Signature]						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38329

AMEND ITEM: #18 PER F.H. G790 12-4-00 WR.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary

Miller

2. Date of Death

Month

Day

Year

Nov. 30, 2000

3. Time of Death

6:29 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

112-05-5458

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar 14, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2405 Mt. Hebron Drive

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office manager/secretary

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Richard Haynes

18. Mother's Name (First, Middle, Maiden Surname)

ANNA CONNELLY

Anna Connelly

19a. Informant's Name/Relationship (Type, Print)

Ms. Patricia A. Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2405 Mt. Hebron Drive Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crest Lawn Memorial Gardens

Date

12/04/00

20c. Location - City or Town, State

Marriottsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. coronary artery disease  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure  
chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

Investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Groman, George S. MD 11085 Little Patuxent Columbia, MD 21044

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38330

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helga Karin Mummert

2. Date of Death  
Month Day Year

Nov 23, 2000

3. Time of Death

4:00 a.m.

4e. Facility Name (If not institution, give street and number)

9214 Spring Valley Rd.

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

219-64-4963

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct 1, 1939

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9214 Spring Valley Rd.

10f. Zip Code

21043

10g. Citizen of What Country?

Germany

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Martin Lattorff

18. Mother's Name (First, Middle, Maiden Surname)

Gertud Ulrich

19a. Informant's Name/Relationship (Type, Print)

Mr. Ronald A. Mummert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9214 Spring Valley Rd. Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

All County Cremation Services, Inc.

Date

11/24/00

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. metastatic sarcoma

Approximate  
Interval Between  
Onset and Death

3 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Derry Mills MD

29c. License number

D26621

29d. Date signed (Month, Day, Year)

November 24 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY MILLES 3460 Ellicott Center Dr., Ellicott City, MD

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

Derry Mills

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
by a physician after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1940 NOV 27 PM 12:06

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38331

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hugh Henry Morris				2. Date of Death Month Day Year 11- 27- 00				3. Time of Death 2:15 PM	
	4a. Facility Name (If not institution, give street and number) Forest Haven Nursing Home				4b. City, Town, or Location of Death Catonsville, Md				4c. County of Death N/A	
Funeral Director	5. Social Security Number 244-14-7022		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth Month Day Year 2/17/27		9. Birthplace (State or Foreign Country) N. Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4226 Flowerton Rd.				10f. Zip Code 21229		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Brown Nursery Co				16b. Kind of Business/Industry Brown Co.	
	17. Father's Name (First, Middle, Last) Lennie Morris				18. Mother's Name (First, Middle, Maiden Summa) Hazel Dalton Morris					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gladys Nedd Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4226 Flowerton Rd, Baltimore, Md. 21229					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Nat. Cem.		20c. Date 12/2/00		20d. Location - City or Town, State Laurel, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTICAEMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERIPHERAL VASCULAR DISEASE DEMEMENTIA									
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Jasneem Lakhani		29c. License number D28595		29d. Date signed (Month, Day, Year) 11/27/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208									
	31. Date filed (Month, Day, Year) DEC 4 2000		32. Registrar's Signature 							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38332

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAMIE B. MARTIN

2. Date of Death

Month

Day

Year

Nov 29, 2000

3. Time of Death

2 15 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

227-18-5065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 15, 1922

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2330 JEFFERSON ST.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

Home.

17. Father's Name (First, Middle, Last)

WM. FRANK TOWNSEND

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE R. CARTER

19a. Informant's Name/Relationship (Type, Print)

MR DANIEL V. TOWNSEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

402 PILOT AVE, FAYETTSVILLE, N.C. 28303

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmont cemetery

Date

12/4/00

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Paul M. Stella

22. Name and Address of Facility

HARTLEY MILLER Funeral Home CHTD.  
7527 HARFORD RD. BALTO. MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Approximate Interval Between Onset and Death

2 YEARS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul M. Stella MD

29c. License number

D 47945

29d. Date signed (Month, Day, Year)

Dec 01, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARIS ALLEN MD 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

-3





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38333

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Albert

Neighoff, Sr.

2. Date of Death

Month

Day

Year

Nov.

30

2000

3. Time of Death

5:55 AM

4a. Facility Name (If not institution, give street and number)

Morningside House-House of Friendship

4b. City, Town, or Location of Death

Hanover

4c. County of Death

Anne Arundel

5. Social Security Number

217-01-7590

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 5, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

948 Circle Drive

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Builder

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

George Neighoff

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Kendall

19a. Informant's Name/Relationship (Type, Print)

Barbara Bernard- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

948 Circle Drive, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

12-02-  
2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home, Inc

1630 Edmondson Avenue, Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cancer Colon

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) assisted living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31726

29d. Date signed (Month, Day, Year)

12/1/00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

RAAFAT Y. GIRGIS - 724 Maiden Choice LA. Catonsville MD

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38334

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES EDWARD ODOM</b>				2. Date of Death Month Day Year <b>NOV. 28, 2000</b>		3. Time of Death <b>3:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>8031 BALTIMORE ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-22-2345</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 29, 1926</b>		
	9. Birthplace (State or Foreign Country) <b>ALABAMA</b>		10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>COLGATE</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>8031 BALTIMORE ST.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>1945-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTOMIZE AUTO</b>		16b. Kind of Business/Industry <b>AUTO</b>		17. Father's Name (First, Middle, Last) <b>ROLAND CULVERSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ERLENE FLEMING</b>	
19a. Informant's Name/Relationship (Type, Print) <b>PHYLLIS L. ODOM/WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3031 BALTIMORE ST., BALTIMORE, MD. 21224</b>		20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HOLLY HILL CEMETERY</b>		20c. Location - City or Town, State <b>12/1/00 BALTIMORE, MD.</b>	
21. Signature of Funeral Service Licensee <i>Elizabeth Schuck</i>		22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Metastatic Colon Cancer</b>		Approximate Interval Between Onset and Death <b>3 yrs</b>			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)		27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>M.D.</i>		29c. License number <b>045390</b>		29d. Date signed (Month, Day, Year) <b>11/28/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MYO MAN (AND) 6850 HOSPITAL DR. # 200, BALTIMORE, MD 21237</b>		31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38335

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Phillips</b>				2. Date of Death Month Day Year <b>Nov. 28, 2000</b>				3. Time of Death <b>15:37</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Johns Hopkins Bayview Medical Ctn.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>214-34-3824</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b>		8. Date of Birth (Month, Day, Year) <b>08-31-13</b>		9. Birthplace (State or Foreign Country) <b>VA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1023 Lenton Avenue</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd. Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>			16b. Kind of Business/Industry <b>never worked</b>		
	17. Father's Name (First, Middle, Last) <b>James Mayo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Luciden Hendricks</b>					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Morton</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1023 Lenton Avenue Baltimore, Maryland 21212</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		Date <b>12-02-2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee <i>Guberville Cook</i>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Asystole</b> Due to (or as a consequence of): <b>b. Myocardial infarction</b> Due to (or as a consequence of): <b>c. coronary artery disease</b> Due to (or as a consequence of): <b>d. unknown</b>									
	23b. Approximate Interval Between Onset and Death <b>15 seconds</b> <b>one hour</b> <b>unknown</b>									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Hypertension</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>Lisa Rosenberg MD</i>				29c. License number <b>DS60018</b>		29d. Date signed (Month, Day, Year) <b>December 2, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lisa Rosenberg, MD 5505 Hopkins Bayview Circle Baltimore, MD 21224</b>									
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <i>[Signature]</i>								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38336

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BENJAMIN BERNARD PRESS</b>			2. Date of Death Month <b>NOV</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>9 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE NURSING HOME</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-09-3097</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 7, 1915</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2500 W. BELVEDERE AVENUE #306</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DRIVER</b>		16b. Kind of Business/Industry <b>CAB COMPANY</b>		
17. Father's Name (First, Middle, Last) <b>HYMAN PRESS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ETHEL FOX</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MANUEL PRESS / BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6092 PETUNIA ROAD - DEL RAY BEACH, FL 33484</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD FREE STATE POST #167</b>		Date <b>12/1/00</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End stage Dementia</b> Due to (or as a consequence of): <b>b. Parkinsonism</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c. Congestive Heart Failure</b>							Approximate Interval Between Onset and Death <b>1 yr</b> <b>1 yr</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>044817</b>		29d. Date signed (Month, Day, Year) <b>DEC. 1st 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Samir Majani 2434 W Belvedere ave, Baltimore -</b>							
31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38337

amend item 18 per fh G791 1/17/01 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Dennis Proctor				2. Date of Death Month Day Year November 30, 2000		3. Time of Death 10:10 PM	
	4a. Facility Name (If not Institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-60-1070		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/30/1952	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10a. Street and Number 5911 Lillyan Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry MTA			
	17. Father's Name (First, Middle, Last) Norman Rose Proctor				18. Mother's Name (First, Middle, Maiden Surname) Catherine Virginia Jung Lorraine Virginia Jung			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharon Proctor/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 Lillyan Avenue Baltimore, Maryland 21206			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus		Date 12/4/00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. multiple myeloma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death 4 years							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number 025205		29d. Date signed (Month, Day, Year) December 1, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. Ley GBMC 6701 N. Charles St. Balto md 2120x							
31. Date filed (Month, Day, Year) DEC 4 2000				32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38338

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Albert Reginald Ross</b>				2. Date of Death Month Day Year <b>November 24 2000</b>				3. Time of Death <b>12:42 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1328 West Lanvale Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-52-7493</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>06-10-50</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1328 W. Lanvale Street</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>2yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Full-time</b>		16b. Kind of Business/Industry <b>Glenmount Elem. Sch.</b>					
	17. Father's Name (First, Middle, Last) <b>Albert Ross</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marilyn Curtis</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Diana Ross</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21216 1713 Braddish Avenue Baltimore, Maryland</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 12-04-2000 Owings Mill</b>		20c. Location - City or Town, State <b>MD</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death) a. <b>Septicemic Shock</b> Due to (or as a consequence of): b. <b>With Embolism of the Liver</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Chronic Alcoholism</b>									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 25, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODOR M. KING 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38339

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Mary Rosenthal</b>				2. Date of Death Month Day Year <b>Nov. 27 2000</b>		3. Time of Death <b>6:13 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Woods Nursing Home</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220-32-2834</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 10 1912</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rosedale</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>6710 Ridge Road</b>				10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>own home</b>	
17. Father's Name (First, Middle, Last) <b>Edward Curran</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Noonan</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Frank Rosenthal Jr. / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>598 Laguna Royale Blvd. Naples FL 34119</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>			Date <b>12/1/2000</b>		20c. Location - City or Town, State <b>Baltimore MD</b>	
21. Signature of Funeral Service Licensee <b>B. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 MACE AVE. Baltimore MD 21221</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>								Approximate Interval Between Onset and Death <b>10 Days</b>
Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>myocardial Infarction</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>S. Ragurey MD</b>				29c. License number <b>D53720</b>		29d. Date signed (Month, Day, Year) <b>11/29/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>S. Ragurey MD, 2112 Belair Rd #9, Fallston, MD 21047</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>S. Ragurey</b>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)  
Julia M. Roberts

2. Date of Death  
Month November Day 30 Year 2000

3. Time of Death  
5:50PM

4a. Facility Name (If not institution, give street and number)  
Manor Care- Rossville

4b. City, Town, or Location of Death  
Baltimore

4c. County of Death  
Baltimore

5. Social Security Number  
209-16-1341

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
89 Yrs.

8. Date of Birth (Month, Day, Year)  
Feb. 13, 1911

9. Birthplace (State or Foreign Country)  
Pennsylvania

10a. State  
MD

10b. County  
Baltimore

10c. City, Town or Location  
Baltimore

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
930 Grove Avenue

10f. Zip Code  
21222

10g. Citizen of What Country?  
U.S.A.

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 7 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Owner

16b. Kind of Business/Industry  
Restaurant

17. Father's Name (First, Middle, Last)  
Adalbert Dudek

18. Mother's Name (First, Middle, Maiden Surname)  
Helen Narkunus

19a. Informant's Name/Relationship (Type, Print)  
Connie Roberts- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
1603 Lynch Road Baltimore, Maryland 21222

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Parkwood Cemetery

20c. Location - City or Town, State  
12/4/00 Baltimore, Maryland

21. Signature of Funeral Service Licensed  
Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
a. Archy Themic Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number  
D45475

29d. Date signed (Month, Day, Year)  
12-1-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Dr. Rahnama 8100 Harford Road Baltimore, Maryland

31. Date filed (Month, Day, Year)  
DEC 4 2000

32. Registrar's Signature  
B. Books

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38341

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Lawrence</u>		2. Date of Death Month <u>November</u> Day <u>29</u> Year <u>2000</u>		3. Time of Death <u>6:30 A.M.</u>
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>214-44-4862</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>55</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>5-23-45</u>		9. Birthplace (State or Foreign Country) <u>AL</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>618 Dumbarton Ave</u>			10f. Zip Code <u>21218</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>African American</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laborer</u>		16b. Kind of Business/Industry <u>Moving Company</u>	
17. Father's Name (First, Middle, Last) <u>Lawrence Ruffin, Sr.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Ruffin</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Catherine Howard/Sister</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>618 Dumbarton Ave, Baltimore, MD 21218</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion Cemetery</u>		20c. Location - City or Town, State <u>Lansdowne, MD</u>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <u>Hari P. Close Funeral Service, P.A. 709 Tessier St., Baltimore, MD 21201-1925</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>End stage Renal disease</u>			Approximate Interval Between Onset and Death <u>1 year</u>
		Due to (or as a consequence of):			
		b. <u>Pulseless Electrical Activity</u>			<u>20 min.</u>
		Due to (or as a consequence of):			
		c.			
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Seizure Disorder</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>DECEMBER 1, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ERIC JACOBSEN MD, Tower 110, Johns Hopkins Hospital Baltimore Maryland 21205</u>					
31. Date filed (Month, Day, Year) <u>DEC 4 2000</u>		32. Registrar's Signature 			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38342

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUKE RAMEY</b>				2. Date of Death Month Day Year <b>NOVEMBER 23 2000</b>		3. Time of Death <b>17:28</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL BAYVIEW</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-84-8117</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 2, 1956</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>WHITE MARSH</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>P.O. BOX 81</b>		10f. Zip Code <b>21162</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DISABLE</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>LUKE RAMEY</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>MADELINE STILNER</b>		19a. Informant's Name/Relationship (Type, Print) <b>LUKE RAMEY/FATHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 81, WHITE MARSH, MD. 21162</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE WASHINGTON CREMATORY</b>		20c. Date <b>11/29/00</b>		20d. Location - City or Town, State <b>LAUREL, MD.</b>		21. Signature of Funeral Service Licensee <b>Elizabeth Seaneke</b>	
	22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> Due to (or as a consequence of): <b>ASPIRATION PNEUMONIA</b> Due to (or as a consequence of): <b>OBSTRUCTIVE SLEEP APNEA</b> Due to (or as a consequence of): <b>OBESITY HYPOVENTILATION SYNDROME</b>		Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>1 WEEK</b> <b>YEARS</b> <b>YEARS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	23c. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
State Registrar	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Sam Blagel MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 23 2000</b>	
DHHM 16 Rev 6/95	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laura Herpel 600 NORTH WOLFE STREET NEWMAN 106 BALTIMORE MD 21227</b>		31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>[Signature]</b>		ORIGINAL	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38343

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUE MARGARET STITH

2. Date of Death

November 29 2000

3. Time of Death

4:05am

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-38-9850

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT 31 1915

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE,

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

904 E BIDDLE STREET

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

PEARLIE CHATMAN

19a. Informant's Name/Relationship (Type, Print)

Beatrice Stokes/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

904 E. Biddle St., Baltimore, Maryland 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Data

12-5-00 OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA  
1206 W NORTH AVENUE

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction  
Due to (or as a consequence of):

&lt; 6 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intrauterine Bleeds

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

024276

29d. Date signed (Month, Day, Year)

12-1-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simon V Scalica 2801 Foster Ave Baltimore MD 21224

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 23 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at office.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38344

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK ROBERT SCALLIO</b>				2. Date of Death Month <b>Dec</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>12-25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Catonsville</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-24-6522</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 30, 1930</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number <b>401 S. Bentalou Street</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Corrections Officer</b>		16b. Kind of Business/Industry <b>State Penitentiary</b>		
17. Father's Name (First, Middle, Last) <b>Santos Scallio</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Monshower</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Susan Scallio-Herd/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Patapsco Road, Linthicum, Maryland 21090</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>12/4/2000 Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Coronary artery disease</b> Due to (or as a consequence of): <b>b. Renal failure</b> Due to (or as a consequence of): <b>c. Diabetes Mellitus</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Decubitus ulcer</b> <b>Emphysema</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D21649</b>		29d. Date signed (Month, Day, Year) <b>Dec, 1, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SAMBANDAM BASKARAN, 3455 W. Wilkens Ave, BALTIMORE MD 21229</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>				32. Registrar's Signature 				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38345

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK SIGELMAN</b>		2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>14:52 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212-09-0780</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEB. 22, 1914</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6 POMONA SOUTH #4</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER</b>		16b. Kind of Business/Industry <b>RETAIL</b>	
17. Father's Name (First, Middle, Last) <b>LOUIS SIGELMAN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA WHITE</b>		
19a. Informant's Name/Relationship (Type, Print) <b>CASPER SIGELMAN / BROTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 POMONA WEST #1 - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN CEMETERY</b>		20c. Location - City or Town, State <b>12/1/00 WOODLAWN, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. <b>MULTISYSTEM ORGAN FAILURE</b>			Approximate Interval Between Onset and Death <b>3/4 Hour</b>
Due to (or as a consequence of):		f. <b>ACUTE MYOCARDIAL INFARCTION</b>			<b>1 HOUR</b>
Due to (or as a consequence of):		g. <b>RESPIRATORY DISTRESS</b>			<b>1 1/4 HOUR</b>
Due to (or as a consequence of):		h.			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>	
29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARC BENNETT, MD SINAI HOSPITAL</b>					
31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature 			

ORIGINAL

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38346

STONE, NANNETTE 11-29-20 10 PM

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-1000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner  
Funeral Director

1. Decedent's Name (First, Middle, Last) Nanette E. Stone		2. Date of Death Month: November Day: 29, Year: 2000		3. Time of Death 10:15 PM	
4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 214-40-8370		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 12/24/1942
9. Birthplace (State or Foreign Country) Pennsylvania					
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3920 Fait Avenue			10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Lutheran Church
17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, Maiden Surname) Mary (Unknown)		
19a. Informant's Name/Relationship (Type, Print) Orville D. Stone			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3920 Fait Avenue Baltimore, Maryland 21224		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 12/2/00	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee <i>Richard J. ...</i>		22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, Maryland 21224			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Lung cancer Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):					Approximate Interval Between Onset and Death 6 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Dr. Anthony Riley, MD</i>		29c. License number 025205		29d. Date signed (Month, Day, Year) November 30, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GPMC 6701 N. Charles St. Balto. MD 21204					
31. Date filed (Month, Day, Year) DEC 4 2000		32. Registrar's Signature <i>[Signature]</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38347

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY Thomas Sible</b>				2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>8:40 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>Genesis Eldericare</b>				4b. City, Town, or Location of Death <b>Brooklyn Park</b>		4c. County of Death <b>AA</b>						
Funeral Director	5. Social Security Number <b>194-09-6065</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 12 1915</b>						
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD</b>		10b. County <b>AA</b>		10c. City, Town or Location <b>BALTO</b>						
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>520 Taney Ave</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PACKER</b>		16b. Kind of Business/Industry <b>Esskay Foods</b>									
17. Father's Name (First, Middle, Last) <b>George Sible</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Isabel Harold</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Thelma May Sible/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>520 Taney Ave. BALTO. MD. 21225</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>12-2-00 Woodlawn MD</b>		20d. Date							
21. Signature of Funeral Service Licensee <b>Demp P. Charlton</b>				22. Name and Address of Facility <b>Altensburg F.H.P.A 6004 HARFORD Rd BALTO MD 21214</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Hypoxemia</b> Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>2 days</b>   <b>1 WEEK</b> </td> </tr> <tr> <td>b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Hypoxemia</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>2 days</b>  <b>1 WEEK</b>	b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):	d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Hypoxemia</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>2 days</b>  <b>1 WEEK</b>											
	b. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):												
	c. _____ Due to (or as a consequence of):												
	d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b> <b>Coronary Artery Disease</b> <b>Congestive heart failure</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>P. H. MD</b>				29c. License number <b>D53462</b>		29d. Date signed (Month, Day, Year) <b>11/29/00</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jude Muneses MD 7845 Oakwood Road Glen Burnie MD 21061</b>													
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>				32. Registrar's Signature <b>[Signature]</b>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38348

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Francis Sanders

2. Date of Death

November 29 2000

3. Time of Death

6:50 A.M.

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-01-4921

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1/24/1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6600 Ridge Road

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

Candel Company

17. Father's Name (First, Middle, Last)

John Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Mary Langer

19a. Informant's Name/Relationship (Type, Print)

Wilma Stiwinter/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 E. Elm Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

12/4/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident  
3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

00054103

29d. Date signed (Month, Day, Year)

November 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM FROHNA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

DEC 4 2000

32. Registrar's Signature

*[Signature]*

State Registrar

ORIGINAL

SANDERS, CHARLES  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38349

NAME KNOWN TO PHYSICIAN: TRAYER, ELSIE C.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Elsie Christina Trayer</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>11:45 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>VA MARYLAND HEALTHCARE SYSTEM</b>		4b. City, Town, or Location of Death <b>PERRY POINT</b>		4c. County of Death <b>CECIL</b>	
5. Social Security Number <b>214-01-6451</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Aug 29, 1919</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>713 214th Street</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Social Security Admin.</b>	
17. Father's Name (First, Middle, Last) <b>William H. Grammer</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Lee Clarke</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Pamela J. Fisher / daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>713 214th Street, Pasadena, Maryland 21122</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National Cem.</b>		20c. Location - City or Town, State <b>12/5/00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. <b>HYPOTHYROIDISM</b> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>UNKNOWN</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADVANCED ALZHEIMER'S DISEASE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D19402</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 01, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SUKH DEV S. AUJLA, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902</b>					
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature 			

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38350

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Robert E. Thomas, SR.</b>		2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>0834</b>
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>
5. Social Security Number <b>168-34-1364</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Sept-16, 1942</b>	9. Birthplace (State or Foreign Country) <b>PA</b>
Usual Residence of Decedent				
10a. State <b>PA</b>	10b. County <b>ADAMS</b>	10c. City, Town or Location <b>GETTYSBURG, PA.</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>2193 CHAMBERG RD.</b>		10f. Zip Code <b>17325</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ROOFER</b>		16b. Kind of Business/Industry <b>CONST. CO.</b>		
17. Father's Name (First, Middle, Last) <b>CHARLES THOMAS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN STEWART</b>		
19a. Informant's Name/Relationship (Type, Print) <b>SUSAN THOMAS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2193 CHAMBERG RD. GETTYSBURG PA</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SMITHSBURG CREMATIUM</b>		20c. Location - City or Town, State <b>12/1/2000 SMITHSBURG, PA</b>
21. Signature of Funeral Service Licensee <b>Paul M. Stella</b>		22. Name and Address of Facility <b>HARTLEY MILLER'S 7577 HARFORD RD.</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. sepsis</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Aspergillus endocarditis</b> <b>lung transplant</b>				Approximate Interval Between Onset and Death <b>24 hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aspergillus endocarditis</b> <b>lung transplant</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Deilyn R. Scott</b>		29c. License number <b>RES 000</b>	29d. Date signed (Month, Day, Year) <b>November 29 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Terilyn R. Scott Johns Hopkins Hospital Tower 110 600 North Wolfe Street Baltimore Maryland 21287</b>				
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38351

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Luis A. Villabon</b>				2. Date of Death Month <b>November</b> Day <b>27</b> , Year <b>2000</b>		3. Time of Death <b>6:00 P.M.</b>											
	4a. Facility Name (If not institution, give street and number) <b>2810 Southern Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>											
Funeral Director	5. Social Security Number <b>216-50-3494</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7/28/1928</b>											
	9. Birthplace (State or Foreign Country) <b>Columbia</b>																	
Usual Residence of Decedent																		
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No											
10e. Street and Number <b>2810 Southern Avenue</b>				10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>U.S.A.</b>												
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify: <b>Columbian</b>			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b> <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pipefitter</b>			16b. Kind of Business/Industry <b>Steel Co.</b>											
17. Father's Name (First, Middle, Last) <b>Luis Villabon</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Nicolasa Ramirez</b>														
19a. Informant's Name/Relationship (Type, Print) <b>Maria Villabon/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2810 Southern Avenue Baltimore, Maryland 21214</b>														
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Cemetery</b>		20c. Date <b>12/1/00</b>		20d. Location - City or Town, State <b>Marriottsville, MD.</b>												
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>John C. Miller Inc.</b> <b>6415 Belair Road Baltimore, Maryland 21206</b>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Pneumonia, aspiration</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>days</b>   <b>years</b> </td> </tr> <tr> <td>b.</td> <td><b>Severe pneumonia, end stage</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Pneumonia, aspiration</b>	Approximate Interval Between Onset and Death  <b>days</b>  <b>years</b>	b.	<b>Severe pneumonia, end stage</b>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Pneumonia, aspiration</b>	Approximate Interval Between Onset and Death  <b>days</b>  <b>years</b>															
	b.	<b>Severe pneumonia, end stage</b>																
	c.																	
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD, BPH, multiple diverticuli ulcer</b> <b>GAD, anemia</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown												
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No												
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No												
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)																
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred										
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <b>Martha C. Raymond</b>				29c. License number <b>054518</b>		29d. Date signed (Month, Day, Year) <b>11/30/00</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARTHA C. RAYMOND 3007 E Northern Parkway Baltimore MD 21214</b>																		
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature 																



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38353

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHERINE THELMA WEINKAM</b>		2. Date of Death Month Day Year <b>NOVEMBER 29 2000</b>		3. Time of Death <b>9:52 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>216-10-2840</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Nov. 6 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>2429 Beach Ave.</b>			10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Hostess</b>		16b. Kind of Business/Industry <b>Middleborough Inn</b>
17. Father's Name (First, Middle, Last) <b>George J Brown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Florence E Fickenscher</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JOann Weiland /daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2429 Beach Ave. Baltimore Md. 21221</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		20c. Location - City or Town, State <b>12/2/2000 Baltimore Md.</b>	
21. Signature of Funeral Service Licensee <b>R. Terry Connolly</b>			22. Name and Address of Facility <b>Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Massive Pulmonary embolism</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Sheldon Milner MD</b>		29c. License number <b>D18598</b>		29d. Date signed (Month, Day, Year) <b>12/1/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHELDON MILNER, MD, 404 EASTERN AVENUE, BALTIMORE, MD 21221</b>					
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Weinkam, Katherine  
Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38352

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edmund F. Waskiewicz				2. Date of Death Month Day Year DEC 2 2000		3. Time of Death 9:00 AM		
	4a. Facility Name (If not Institution, give street and number) 7105 Chamberlain Road				4b. City, Town, or Location of Death Woodlawn		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-18-0965		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76		8. Date of Birth (Month, Day, Year) Nov. 15, 1924		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Woodlawn		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7105 Chamberlain Road		10f. Zip Code 21244		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WW-2 If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Station Owner		16b. Kind of Business/Industry Gas Station					
17. Father's Name (First, Middle, Last) Theofoll Waskiewicz				18. Mother's Name (First, Middle, Maiden Surname) Mary Sohzzak					
19a. Informant's Name/Relationship (Type, Print) Joyce Waskiewicz- Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 Chamberlain Road, Woodlawn, Maryland 21244					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 12/06/2000		20c. Location - City or Town, State Woodlawn, Maryland			
21. Signature of Funeral Service Licensee <i>Kim Schlanges</i>				22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland					
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Acute myocardial infarction</i> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Approximate Interval Between Onset and Death 2 min									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypercholesterolemia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>JW Cook</i>		29c. License number 1044243		29d. Date signed (Month, Day, Year) December 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW Cook MD 1120 N. Rolling Road Catonsville MD 21228									
31. Date filed (Month, Day, Year) DEC 4 2000		32. Registrar's Signature <i>J. [Signature]</i>							

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a perPHYG790 12/4/2000 EW

## Certificate of Death

Reg. No.

00 38354

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY WERNER</b>				2. Date of Death Month <b>11</b> Day <b>25</b> Year <b>00</b>		3. Time of Death <b>0400</b>	
	4a. Facility Name (If not institution, give street and number) <b>Hartford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>216-32-2881</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 11, 1928</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>	
Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>102 Parkway Avenue</b>				10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'47-53</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race- American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>		
17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anita Baldwin</b>				
19a. Informant's Name/Relationship (Type, Print) <b>unk</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Director <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>Adult Respiratory Distress Syndrome</b> Due to (or as a consequence of):								
b. <b>Pneumonia (Bilateral)</b> Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatic Cancer</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D0055722</b>		29d. Date signed (Month, Day, Year) <b>11/25/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Seong Chin Hartford Memorial Hospital</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>				32. Registrar's Signature <b>P. Sparks</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38355

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PEARL</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>29</b> , Year <b>2000</b>				3. Time of Death <b>6:15PM</b>																																			
	4a. Facility Name (If not institution, give street and number) <b>JEWISH CONVALESCENT HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>BALTIMORE</b>																																			
Funeral Director	5. Social Security Number <b>213-16-6818</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 15, 1908</b>		9. Birthplace (State or Foreign Country) <b>RUSSIA</b>																																			
	Usual Residence of Decedent																																											
To Be Completed by Funeral Director	10e. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																			
	10e. Street and Number <b>1450 BEDFORD AVENUE</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>																																					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>			16b. Kind of Business/Industry <b>CLOTHING</b>																																				
	17. Father's Name (First, Middle, Last) <b>MOTLE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SHANA ZEISEL</b>																																							
Physician /Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>MARVIN WIES / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>48 PENNY LANE - BALTIMORE, MD 21209</b>																																							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHIZUK AMUNO (ARLINGTON)</b>		Date <b>12/1/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>																																					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>																																							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																											
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td colspan="7">congestive cardiomyopathy</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>2 years</b></td> </tr> <tr> <td>b.</td> <td colspan="7">atherosclerosis of coronary arteries</td> <td rowspan="3">distant</td> </tr> <tr> <td>c.</td> <td colspan="7"></td> </tr> <tr> <td>d.</td> <td colspan="7"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	congestive cardiomyopathy							Approximate Interval Between Onset and Death <b>2 years</b>	b.	atherosclerosis of coronary arteries							distant	c.								d.						
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	congestive cardiomyopathy							Approximate Interval Between Onset and Death <b>2 years</b>																																			
	b.	atherosclerosis of coronary arteries								distant																																		
	c.																																											
	d.																																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>D25001</b>		29d. Date signed (Month, Day, Year) <b>11-30-00</b>																																				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAY LIPPMAN, MD 10085 Red Run Blvd Owings Mills MD 21117</b>																																												
31. Date filed (Month, Day, Year) <b>DEC - 4 2000</b>		32. Registrar's Signature 																																										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JAMES ANDERSON

State of Maryland / Department of Health and Mental Hygiene

00 38356

ASP AMEND ITEM: 19A PER 19A PER F.H. G790 12-5-00 WR. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES ANDERSON</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>25</b> Year <b>2000</b>				3. Time of Death <b>1040</b>		
	4a. Facility Name (If not Institution, give street and number) <b>1410 E. OLIVER ST.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-10-9064</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MARCH 19, 1925</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>		
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>1410 E. OLIVER ST. #109</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BRICK LAYER</b>		16b. Kind of Business/Industry <b>Construction Co.</b>				
	17. Father's Name (First, Middle, Last) <b>JOHN ANDERSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSA THORNTON</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA JONES (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5621 APPETREE ST - PHILA, PENN. 19139</b>						
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA.</b>		Date <b>12/5/00</b>		20c. Location - City or Town, State <b>OWEN'S MILLS, MD</b>				
	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>BETTS FUNERAL HOME</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate interval Between Onset and Death						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES</b> <b>PROSTRATE CANCER</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 28, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute mo</b>						111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 23,27,&amp;28a-f per ME G793 030901SS

Certificate of Death

Reg. No.

00 38357

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

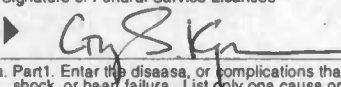
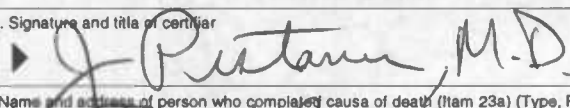
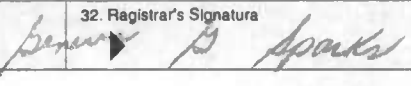
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
Medical  
ExaminerFuneral  
DirectorPhysician  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Isabel Eloisa Ayala</b>		2. Date of Death Month Day Year <b>November 30, 2000</b>		3. Time of Death <b>7:05 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>		4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
5. Social Security Number <b>214-59-0545</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. Months Days <b>2 10</b>	8. Date of Birth (Month, Day, Year) <b>Sept 20, 2000</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent					
10a. State <b>Md.</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Savage</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>9056 Baltimore Street</b>		10f. Zip Code <b>20763</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Mexican</b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>	
16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Benjamin Ayala</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Susan Jacobs</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Susan Jacobs / mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9056 Baltimore Street Savage, Md. 20763</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Dec 2, 2000 Catonsville, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Md. 20707</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SUDDEN INFANT DEATH WHILE CO-SLEEPING</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) found: <b>11-30-00</b>		28b. Time of Injury found: <b>6:25 AM</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found at home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>9056 Baltimore St., Savage, MD</b>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 01, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>DEC - 5 2000</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38358

amend item 23a,27,28a,b,c,d,e,f per me G790 12/13/00 yf Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEROME ADAMS</b>		2. Date of Death Month Day Year <b>DECEMBER 02, 2000</b>		3. Time of Death <b>11:22 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3700 GREENSPRING AVENUE APARTMENT 207</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-88-0061</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>31</b> Yrs.	
	8. Date of Birth (Month, Day, Year) <b>APRIL 29, 1969</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
	10d. Street and Number <b>2228 NORTH MONROE ST.</b>		10e. Zip Code <b>21217</b>		10f. Citizen of What Country? <b>USA.</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th GRADE</b> College (1-4 or 5+) <b>DISABLED</b>		16. Kind of Business/Industry <b>N/A</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIE ADAMS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ESTELLE WILLIAMS</b>		19. Informant's Name/Relationship (Type, Print) <b>ESTELLE ADAMS (MOTHER)</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2228 NORTH MONROE ST. BALTO. MD. 21217</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 12-8-00 LANSDOWNE, MARYLAND</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ACUTE NARCOTIC AND COCAINE INTOXICATION</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <b>found: 12/2/00</b>		28b. Time of Injury <b>found: 11:11 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>unknown</b>		28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) <b>found at home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>3700 Greenspring Ave. Apt. 207 Baltimore, Maryland</b>	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>DECEMBER 03, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chuterio 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>DEC - 5 2000</b>	
	32. Registrar's Signature 		33. State Registrar <b>DEC - 5 2000</b>		34. Original	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38359

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lucille Marie Armstrong</i>				2. Date of Death Month <i>November</i> Day <i>28</i> , Year <i>2000</i>		3. Time of Death <i>11:30 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Stella Maris</i>				4b. City, Town, or Location of Death <i>Timonium</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>220-38-5306</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>100</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>May 26, 1900</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Timonium</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>2300 Dulaney Valley Road</i>			10f. Zip Code <i>21093</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>n/a</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Own HOME</i>			
	17. Father's Name (First, Middle, Last) <i>William Holliday</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Lula Gonc</i>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>John E. Armstrong, Jr./Son</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>200 Belmont Forest Ct., Timonium, MD 21093</i>				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>		Date <i>12/1/00</i>		20c. Location - City or Town, State <i>Woodlawn, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>Bryan W. Clagg</i>		22. Name and Address of Facility <i>Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>CEREBROVASCULAR ACCIDENT</i>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GENEVA/ISA 12/1/00</i>							
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Immediate Cause (Final disease or condition resulting in death)		a. <i>CEREBROVASCULAR ACCIDENT</i>		Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b.		Due to (or as a consequence of):			
			c.		Due to (or as a consequence of):			
			d.		Due to (or as a consequence of):			
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>[Signature]</i>							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>D 15504</i>		29d. Date signed (Month, Day, Year) <i>12-1-00</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</i>								
31. Date filed (Month, Day, Year) <i>DEC 05 2000</i>				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38360

Amended Item#23a,26,28c perPHYG790 12/5/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Geraldine D. Broccolino				2. Date of Death Month Day Year DECEMBER 1, 2000				3. Time of Death 5:10 PM	
	4a. Facility Name (If not institution, give street and number) Union Memorial				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a	
Funeral Director	5. Social Security Number 219-28-2940		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 9-30-1930	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Baltimore, MD							
To Be Completed by Funeral Director	10e. State MD		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2400 Lake Avenue				10f. Zip Code 21213		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 2				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Music Teacher			16b. Kind of Business/Industry Saint Francis of Assisi School		
	17. Father's Name (First, Middle, Last) Joseph Defina				18. Mother's Name (First, Middle, Maiden Surname) Filomena (Fannie) Graziaplana					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Husband Nicholas V. Broccolino				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 Lake Avenue, Baltimore, Maryland 21213					
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entomb				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley		Data 12/5/00		20c. Location - City or Town, State Baltimore, Co. Maryland	
	21. Signature of Funeral Service Licensee Maria H. Zannino				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Syndrome Due to (or as a consequence of): b. Bowel Ischemia Due to (or as a consequence of): c. Necrotizing Fasciitis Due to (or as a consequence of): d. Chronic Steroid Use						Approximate Interval Between Onset and Death 7 days 7 days 7 days 2 years			
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.				29d. Date signed (Month, Day, Year) DECEMBER 1, 2000						
29b. Signature and title of certifier Stacy D. Garrett, MD				29c. License number 13182						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stacy Garrett, Union Memorial Hospital, 201 E. University Parkway, Balto. MD 212										
31. Date filed (Month, Day, Year) DEC 05 2000				32. Registrar's Signature Benita B. Sparks						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

9



00 3836

ORIGINAL



## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Mason Nicholas John Barnes				2. Date of Death Month Day Year NOVEMBER 29 2000				3. Time of Death 0612 A.M.			
4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				4b. City, Town, or Location of Death ESSEX				4c. County of Death BALTIMORE			
5. Social Security Number NONE		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 1 20		8. Date of Birth (Month, Day, Year) Oct. 9, 2000		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent											
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 930 Gladway Road				10f. Zip Code 21220		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none				16b. Kind of Business/Industry none			
17. Father's Name (First, Middle, Last) Stephen P. Connors				18. Mother's Name (First, Middle, Maiden Surname) Tammy Lee Lois Barnes							
19a. Informant's Name/Relationship (Type, Print) John Wesley Barnes, Jr. (Grandfather)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12303 Philadelphia Road, Bradshaw, Md. 21287							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory		20c. Date 12/2/2000		20d. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221							
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. ASPHYXIATION DUE TO OVERLAY Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> POA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/29/00		28b. Time of Injury 5:25 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred infant was overlaid by an adult			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 830 Gladway Rd., Middle River, Md							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) NOVEMBER 30, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC - 5 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0003.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38363

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irma M. Baker</b>				2. Date of Death Month Day Year <b>Nov. 29, 2000</b>				3. Time of Death <b>10:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>413 W. 24th Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>215-14-5725</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>July 15, 1908</b>		
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>										
Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>413 W. 24th Street</b>				10f. Zip Code <b>21211</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>				16b. Kind of Business/Industry <b>Shipping</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Kisch</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Magdalene Horvath</b>						
19a. Informant's Name/Relationship (Type, Print) <b>George Baker Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9753 Bird River Road Baltimore, Maryland 21220</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial</b>		Date <b>12/04/00</b>		20c. Location - City or Town, State <b>Cockeysville, MD</b>			
21. Signature of Funeral Service Licensee <b>Lynn B. Heness</b>					22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Valvular heart disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Pulmonary Emboli</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>Betsy A. Fay MD</b>			29c. License number <b>D33220</b>		29d. Date signed (Month, Day, Year) <b>12/1/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Betsy A. FAY MD 3730 Falls Road BALTIMORE, MD 21211</b>											
31. Date filed (Month, Day, Year) <b>DEC 03 2000</b>			32. Registrar's Signature <b>Sparks</b>								

Baltimore, Maryland 21215-0036

permlt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 38364

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn L. Barber				2. Date of Death Month Day Year November 24, 2000				3. Time of Death 6:14 P.M.		
	4a. Facility Name (If not institution, give street and number) St. Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-62-6877		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) 11-4-1946		9. Birthplace (State or Foreign Country) D.C.		
	Usual Residence of Decedent										
10a. State Md		10b. County Balto		10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10a. Street and Number 12110 Sugar Mill Circle				10f. Zip Code 21220				10g. Citizen of What Country? U S A			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) Carroll Holland				18. Mother's Name (First, Middle, Maiden Surname) Mary Brooks							
19a. Informant's Name/Relationship (Type, Print) Alice Kerrick - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Dolfield Avenue Baltimore, Md 21215							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Zion Cemetery		Date 12-5-00		20c. Location - City or Town, State Lansdown, Md					
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Left Heart Failure due to Aortic Embolism Complicating</i> Due to (or as a consequence of): b. <i>Swain-Jay procedure during Aortic Curvature</i> Due to (or as a consequence of): c. <i>Open Bypass Left Surgery</i> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 11/24/00		28b. Time of Injury 0830A		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>injection associated with</i> <i>placement of</i> <i>operating room Towson Maryland 21204</i>			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 26, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THE MORE MORGAN</i>				111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) DEC 5 2000				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38365

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS WAYNE

BURNOPP, SR.

2. Date of Death

November 27 2000

3. Time of Death

7:48A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-24-2918

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 6, 1930

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 GAMBRILLS ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1951-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
N/A

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

MAINTENANCE

17. Father's Name (First, Middle, Last)

HOWELL

BURNOPP

18. Mother's Name (First, Middle, Maiden Surname)

PEARL

BAILEY

19a. Informant's Name/Relationship (Type, Print)

MRS. CHARLOTTE R. BURNOPP

(WIFE)

101 GAMBRILLS ROAD, SEVERN, MARYLAND 21144

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date 11/30/2000

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Acute Myocardial Infarction

Due to (or as a consequence of):

b.

Cardiogenic Shock

Due to (or as a consequence of):

c.

Abdominal Aortic Aneurysm

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43977

29d. Date signed (Month, Day, Year)

November 27 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Angela Ostermij: 301 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

[Signature]

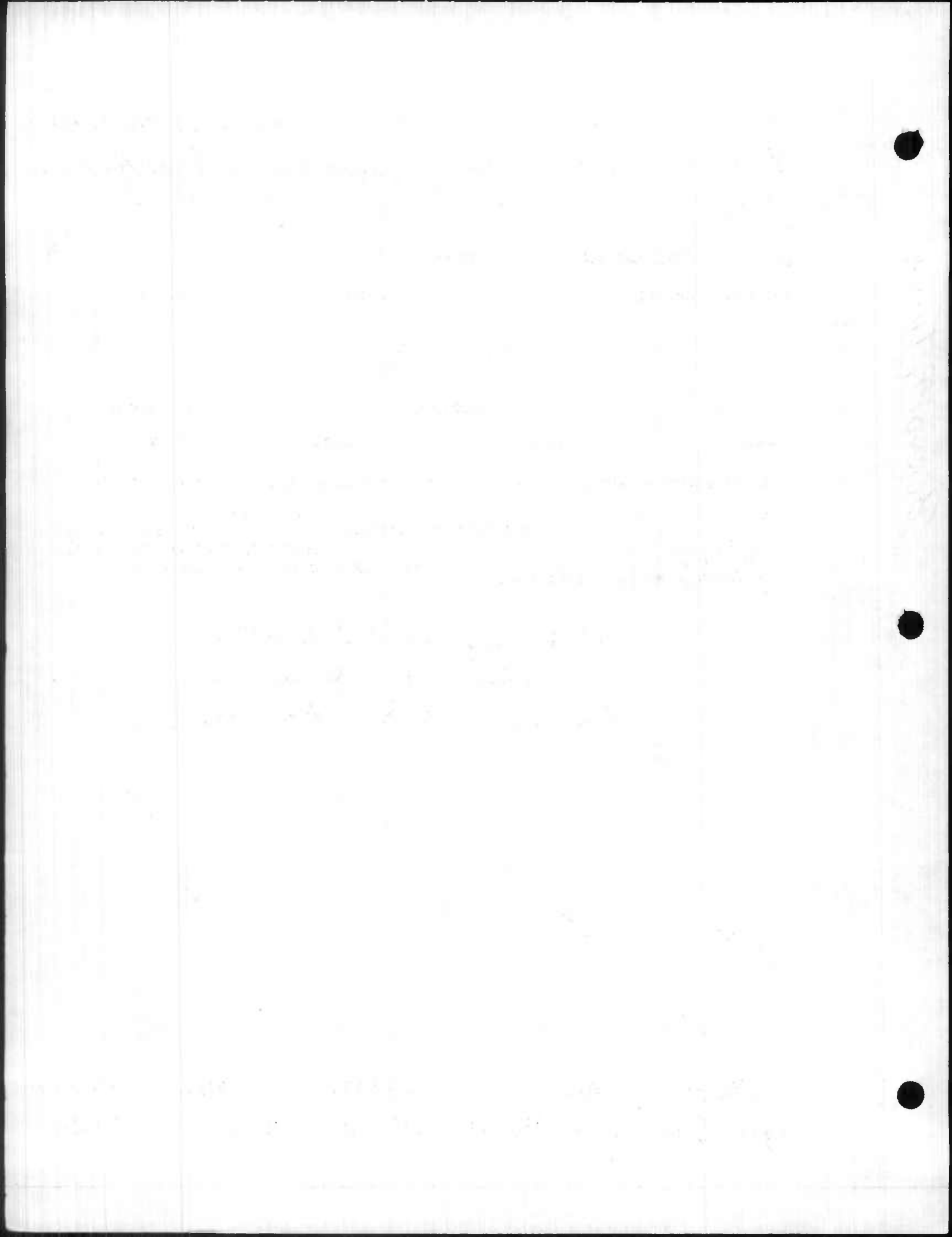
State  
RegistrarBURNOPP, THOMAS  
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,  
To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38366

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ASHLEY CLAY BOOTH</b>				2. Date of Death Month <b>December</b> Day <b>01</b> Year <b>2000</b>		3. Time of Death <b>3:40 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-90-2062</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>22</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 1, 1978</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>GAMBRILLS</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>225 PEGASUS COURT</b>		10f. Zip Code <b>21054</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TECH #3</b>		16b. Kind of Business/Industry <b>FIBEROPTICS &amp; TELECOMMUNICATIONS</b>				
17. Father's Name (First, Middle, Last) <b>GEORGE A. BOOTH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SHERAN LEE TURNER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MR. GEORGE A. BOOTH (FATHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>225 PEGASUS COURT, GAMBRILLS, MARYLAND 21054</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALDWIN MEMORIAL U.M. CHURCH CEMETERY</b>		Date <b>12/4/2000</b>		20c. Location - City or Town, State <b>MILLERSVILLE, MD.</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Singleton Funeral Home, PA 1 Second Ave. S.W. Glen Burnie, Maryland 21061</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. MULTIPLE INJURIES</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>12/1/00</b>		28b. Time of Injury <b>0211</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <b>PASSENGER OF CAR WHICH STRUCK A FIXED OBJECT</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>NEW CUT ROAD SEVERN, MD</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>December 03, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38367

amend item 23a,b,c,d,27,28a,b,c,d,ef, per me G790 12/6/00

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Macy L. Brooks Sr.</b>				2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>3:22 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-56-4850</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 14, 1950</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1010 S. Baylis Street</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>Usa</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 yrs.</b> College (1-4 or 5+) <b>Operator</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>			16b. Kind of Business/Industry <b>Paving</b>		
	17. Father's Name (First, Middle, Last) <b>Macy K. Brooks</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Alice Pennepacker</b>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jenny Brooks wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1010 S. Baylis St. Baltimore, Md. 21224</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery</b>		Date <b>Dec 2, 2000</b>		20c. Location - City or Town, State <b>Middle River, Md.</b>	
	21. Signature of Funeral Service Licensee <i>Anthony C. Connelly</i>				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>GASTROINTESTINAL HEMORRHAGE</b> Due to (or as a consequence of):</p> <p>b. <b>RUPTURED ESOPHAGEAL VARICES</b> Due to (or as a consequence of):</p> <p>c. <b>CIRRHOSIS</b> Due to (or as a consequence of):</p> <p>d. <b>HEPATITIS C INFECTION</b></p> </div> </div>									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>unknown</b>		28b. Time of Injury <b>unknown M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>unknown</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>unknown</b>					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 30, 2000</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. ALAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>									
	31. Date filed (Month, Day, Year) <b>DEC - 5 2000</b>				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38368

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Alice Carnes				2. Date of Death Month Day Year November 30 2000				3. Time of Death 11:15PM		
	4a. Facility Name (If not institution, give street and number) 2454 Cross Section Rd.				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 212-44-3565		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 29 1944		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Md.		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2454 Cross Section Rd.				10f. Zip Code 21158				10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional Officer				16b. Kind of Business/Industry Dept. of Corrections		
	17. Father's Name (First, Middle, Last) Hunter Goss				18. Mother's Name (First, Middle, Maiden Surname) Pauline Elizabeth Poseno						
	19a. Informant's Name/Relationship (Type, Print) Mr. Wilbert L. Carnes, Jr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2454 Cross Section Rd. Westminster, Md. 21158						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Gdns		Date 12-5-00		20c. Location - City or Town, State Sykesville, Md.				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Metastatic breast Cancer 8/3/00 Due to (or as a consequence of): b. Large pleural effusions '93 Due to (or as a consequence of): c. Bone metastasis / lung metastasis ↑ Due to (or as a consequence of): d. Bil. breast Cancer '88										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Patient was in hospice care since 8/3/00										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 	
29c. License number D 38041										29d. Date signed (Month, Day, Year) 12/4/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruchina H. Thakor, MD MPH, 4 W., Rolling Greenroads, Catonsville MD 21228											
31. Date filed (Month, Day, Year) DEC 5 2000										32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#14 per FHG790 12/6/2000 EW

## Certificate of Death

Reg. No.

00 38369

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nui Mei Lee Chung				2. Date of Death Month Day Year December 05, 2000		3. Time of Death 6:20 A.M.	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care-Hamilton Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-84-1991		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) April 19, 1920	
	9. Birthplace (State or Foreign Country) Canton, China		10a. State Maryland		10b. County Montgomery Co.		10c. City, Town or Location Burtonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4229 Red Maple Court		10f. Zip Code 20866-1146		10g. Citizen of What Country? United States of America	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <del>Chinese</del> Asian	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 05 College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Fay Fat Lee				18. Mother's Name (First, Middle, Maiden Surname) Nui Joy Lee			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Yiu Pong Chung (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4229 Red Maple Court Burtonsville, Maryland 20866-1146			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery		20c. Location - City or Town, State 12/11/2000 Woodlawn, Maryland		21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr.	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier		29c. License number D415475	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 12/5/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD RAHMANA, M.D. 8100 Harford Rd Baltimore MD 21234		31. Date filed (Month, Day, Year) DEC 5 2000			
	32. Registrar's Signature B. Sparks				33. State Registrar			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38370

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Constance COHEN

2. Date of Death

November 30 2000

3. Time of Death

2 M

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-20-2879

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 13, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

224 Carnation Court

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Nicholas Takas

18. Mother's Name (First, Middle, Maiden Surname)

Anastasia Psiras

19a. Informant's Name/Relationship (Type, Print)

Mr. James Cohen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2370 Sandy Walk Way Odenton, MD 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Hebrew Congregation Cem. 12/4/00 Reisterstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Dehydration

Due to (or as a consequence of):

c.

Alzheimer disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30339

29d. Date signed (Month, Day, Year)

11/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nolan WINTER, MD 4000 Old Court Rd. Baltimore, MD 21208.

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2000 NOV 23 14:12:23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38371

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bruce Copeland</b>				2. Date of Death Month <b>NOVEMBER 29</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>5:50 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>VAMHS FORT HOWARD DIVISION</b>				4b. City, Town, or Location of Death <b>FORT HOWARD</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-78-3863</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06 05 64</b>	
	9. Birthplace (State or Foreign Country) <b>M.D.</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2735 East Chase Street</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> Collage (1-4or 5+) <b>na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Ware House Fork Lifter</b>		16b. Kind of Business/Industry <b>Roadway Company</b>				
17. Father's Name (First, Middle, Last) <b>Gene Copeland</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ray Conyers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jacqueline Copeland-Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2735 East Chase Street, Baltimore Md 21213</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. 12/6/00 Owings Mills, Md</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC RECTAL CARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number <b>247804</b>		29d. Date signed (Month, Day, Year) <b>11/29/2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR ANDREW MROWIEC, M.D. -- 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052</b>								
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BRUCE COPELAND

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38372

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary R. Castrilli</b>				2. Date of Death Month Day Year <b>Dec. 2, 2000</b>		3. Time of Death <b>9:03AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1908 Woodbourne Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-10-8295</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 11, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1908 Woodbourne Avenue</b>		10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Joseph Lancione</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Nora DeCeasare</b>		19a. Informant's Name/Relationship (Type, Print) <b>Joseph Castrilli- Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2303 Covered Bridge Garth Baltimore, MD 21239</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem.</b>		20c. Date <b>12/6/00</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <b>Heather Cain</b>		
22. Name and Address of Facility <b>Leonard J. Ruck, Inc.</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Arteriosclerotic Cardiovascular Disease</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>Years</b>		
23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D-17041</b>		29d. Date signed (Month, Day, Year) <b>4 DECEMBER 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marc E. Leavey MD 1205 York Road Ste 38 Lutherville MD 21093</b>		31. Data filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>		33. State Registrar <b>DEC 5 2000</b>		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38373

AMEND#18 PER F.H. G790 12-5-2000 JAB

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MABEL CARNEY</b>				2. Date of Death Month <b>DEC</b> Day <b>02</b> Year <b>2000</b>		3. Time of Death <b>7:10 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL, 900 CATON AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-14-7914</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 01 1924</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3008 Ohio Ave.</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home Owner</b>		
17. Father's Name (First, Middle, Last) <b>John A. Hughes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Dolcia DIELCIA Clark</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James R. Carney (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3008 Ohio Ave. Baltimore, Md. 21227</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		Date <b>12/05/2000</b>		20c. Location - City or Town, State <b>Baltimore, MD.</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE MYELOMA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION; ARRHYTHMIA (ATRIAL FIBRILLATION / PSVT), OSTEOPOROSIS, MULTIPLE FRACTURES, THROMBO-EMBOLIC EVENT</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  <b>#196</b>		29c. License number <b>D-44789</b>		29d. Date signed (Month, Day, Year) <b>DEC 02, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KHIN MAUNG U, MD, Dept. of Medicine, ST. AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD 21229.</b>								
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38374

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NEIL A. CAMERON		2. Date of Death Month Day Year NOVEMBER 22, 2000		3. Time of Death 4:43am
	4a. Facility Name (If not institution, give street and number) 1827 ARUNAH AVE.		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 240-34-1876	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 1-2-1928		9. Birthplace (State or Foreign Country) NC		
Usual Residence of Decedent					
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1827 ARUNAH AVE.		10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -4- College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry CHEMICAL	
17. Father's Name (First, Middle, Last) EUROPE CAMERON		18. Mother's Name (First, Middle, Maiden Surname) ORA McNEILL			
19a. Informant's Name/Relationship (Type, Print) STEPHANIE CAMERON (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1827 ARUNAH AVE. BALTIMORE, MARYLAND 21217			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK		20c. Location - City or Town, State 11-29-2000 BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee Jonathan D. Hysie		22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cancer Pancreatic gland with metastases Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 56 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. electrolyte imbalances		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier John D. Gottschalk MD		29c. License number D0032446		29d. Date signed (Month, Day, Year) 11/22/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John D. Gottschalk MD Johns Hopkins 410-955-7128					
State Registrar	31. Date filed (Month, Day, Year) DEC 05 2000		32. Registrar's Signature Benita S. Jones		

ORIGINAL

Neil Cameron 22 November 2000  
Baltimore, Maryland 21215-0020 4:43 AM

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38375

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALBERT MARTIN DECKER</b>				2. Date of Death Month Day Year <b>December 2, 2000</b>		3. Time of Death <b>7:25 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Shock Trauma Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-44-5779</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 14, 1943</b>	
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>234 Linden Ave.</b>		10f. Zip Code <b>21286</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Labeler</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Labeler</b>				16b. Kind of Business/Industry <b>BARC</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Robert K. Decker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara C. Quinn</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Clara C. Decker/mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>234 Linden Ave. Towson, Md. 21286</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial</b>		20c. Location - City or Town, State <b>Timonium, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Injuries</b> Due to (or as a consequence of): <b>b. Brain Trauma</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year) <b>11-14-00</b>				28b. Time of Injury <b>5:04 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>Pedestrian Struck</b>				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>York Road Towson MD</b>				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier 				29c. License number <b>D40386</b>		29d. Date signed (Month, Day, Year) <b>12-4-00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Camell Cooper, MD Shock Trauma Center</b>				31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>			
	32. Registrar's Signature 				33. State Registrar <b>DEC 5 2000</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38376

Amended item#30 perDVRG790 12/14/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Susie Dancy</u>		2. Date of Death Month <u>Dec</u> Day <u>3</u> Year <u>00</u>		3. Time of Death <u>9:10 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>Bon Secours Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>238-39-9159</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>70</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>Mar. 6, 1930</u>		9. Birthplace (State or Foreign Country) <u>North Carolina</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Randallstown</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>4 Redleaf Court</u>			10f. Zip Code <u>21133</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laundry Worker</u>		16b. Kind of Business/Industry <u>Maryland Hospital Laundry</u>	
17. Father's Name (First, Middle, Last) <u>Sherman Cobb</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Bertha Taylor</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Peggy Land - Niece</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4 Redleaf Ct. Balto. MD 21133</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		20c. Location - City or Town, State <u>12/8 Baltimore, MD</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Aspiration pneumonia</u> Due to (or as a consequence of): b. <u>Atherosclerotic Cardiovascular disease</u> Due to (or as a consequence of): c. <u>Seizure disorder</u> Due to (or as a consequence of): d. <u>Cerebrovascular accident</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Amattun H. Naem MD</u>		29c. License number <u>D 15503</u>		29d. Date signed (Month, Day, Year) <u>Dec, 3 00</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Amattun N. Naem Bon Secour Hospital 2000 W. Baltimore ST.</u>					
31. Date filed (Month, Day, Year) <u>DEC 5 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38377

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard Edward Dize					2. Date of Death Month Day Year DECEMBER 4 2000			3. Time of Death 9:00 A.M.		
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER					4b. City, Town, or Location of Death ROSEDALE			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 212-03-2890		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 8, 1911		9. Birthplace (State or Foreign Country) Md.		
	Usual Residence of Decedent										
10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 6628 Hartwait St.					10f. Zip Code 21224		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Yrs. College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool Intendant			16b. Kind of Business/Industry Martins			
17. Father's Name (First, Middle, Last) Thomas Edward Dize					18. Mother's Name (First, Middle, Maiden Surname) Daisy Bright Kimmerly						
19a. Informant's Name/Relationship (Type, Print) Ethel E. Dize wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6628 Hartwait St. Baltimore Md. 21224						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Louden Park			Date Dec 6, 2000		20c. Location - City or Town, State Baltimore			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. INTERSTITIAL LUNG Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 3 MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBRAL VASCULAR ACCIDENT PROSTRATE CANCER										23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number D191825			29d. Date signed (Month, Day, Year) 12/4/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA MATHUR, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237											
31. Date filed (Month, Day, Year) DEC 4 2000			32. Registrar's Signature 								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38378

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SANDRA DISNEY</b>				2. Date of Death Month Day Year <b>DECEMBER 2, 2000</b>		3. Time of Death <b>10:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>109-10-1560</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 14 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6 South Hollins Ferry Road</b>		10f. Zip Code <b>21061</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Household</b>		
17. Father's Name (First, Middle, Last) <b>Charles Russin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Unknown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gayle S. Elliott (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9628 Via Emilie, Boca Raton, Florida 33428</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Date <b>Dec. 5 2000</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  <b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>Fernando A. Lopez MD</b>				29c. License number <b>1296</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO A. LOPEZ MD 22 NORTH GREENE STREET BALTIMORE MARYLAND 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38379

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNETTE DAY

2. Date of Death

December 1, 2000

3. Time of Death

942 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-26-4519

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-14-1934

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10e. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

914 N. CARROLLTON AVE.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-9-

College (1-4 or 5+)

-0-

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CATERING

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

LEE JACKSON

18. Mother's Name (First, Middle, Maiden Surname)

INEZ JACKSON

19a. Informant's Name/Relationship (Type, Print)

SANDRA SMITH (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 N. CARROLLTON AVE. BALTIMORE, MARYLAND 21217

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. ZION CEMETERY

Date

12-7-2000 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.  
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P13531

29d. Date signed (Month, Day, Year)

12/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priya Prabhakar, M.D. to Maryland General Hospital.

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

[Signature]

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38380

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>MARCELLA Eaddy</b>		2. Date of Death Month Day Year <b>NOVEMBER 24, 2000</b>		3. Time of Death <b>17:19 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>1419 EAST EAGER STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
5. Social Security Number <b>216-54-5918</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>8-13-50</b>		9. Birthplace (State or Foreign Country) <b>BALTO.</b>			
10a. State <b>MD.</b>		10b. County		10c. City, Town or Location <b>BALTO.</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1419 E. EAGER ST.</b>		10f. Zip Code <b>21205</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK.</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME MAKER</b>		16b. Kind of Business/Industry <b>HOME.</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM GEATER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>NATHIE JEFFERSON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>RENAE WEAVER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1419 E. EAGER ST. BALTO. MD. 21205</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. CARMEL</b>		20c. Location - City or Town, State <b>12-2-00 BALTO. MD.</b>	
21. Signature of Funeral Service Licensee <b>Chavis F.H.</b>		22. Name and Address of Facility <b>2007 EASTERN AVE BALTO. MD. 21231</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Left Ventricular Hypertrophy</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Theodore A. Hargens</b>	
29c. License number <b>O.C.ME..</b>		29d. Date signed (Month, Day, Year) <b>NOVEMBER 25, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. Kung</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>	
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>James B. Sparks</b>			





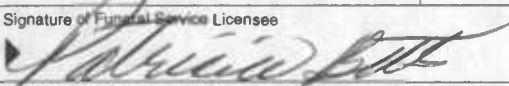
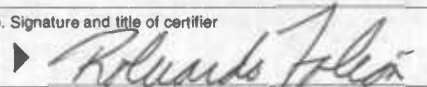

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38381

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Daisy Franklin</b>				2. Date of Death Month <b>December</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>5:32 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>216-20-8014</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/18/1923</b>	
	10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3510 White Chapel</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>2years college</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Personnell Office</b>		16b. Kind of Business/Industry <b>D.C. State Dept DIA</b>		
17. Father's Name (First, Middle, Last) <b>Willie Harris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Matilda Shavers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Alexander Franklin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3510 White Chapel Balto. Md. 21215</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem.</b>		Date <b>12/7/00</b>		20c. Location - City or Town, State <b>Arbutus, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Betts Funeral Home</b> <b>1129 N. Caroline St. Balto. Md. 21213</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart Failure</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia-Vitamin B12 deficiency</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number <b>RES 000</b>
29b. Signature and title of certifier  <b>MD</b>				29d. Date signed (Month, Day, Year) <b>December 1, 2000</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Rolando Falcon 2401 West Belvedere, Baltimore MD 21215</b>								
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38382

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Zerita Y. Fletcher</b>				2. Date of Death Month <b>November</b> Day <b>25</b> Year <b>2000</b>				3. Time of Death <b>0008 am</b>						
	4a. Facility Name (If not institution, give street and number) <b>2400 block of Edmondson Avenue @ Whitmore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>219-80-8241</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>39</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 30, 1961</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>						
	Usual Residence of Decedent														
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No							
10e. Street and Number <b>2545 Aruhah Avenue</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>									
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>Custodian</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Cleaning Company</b>								
17. Father's Name (First, Middle, Last) <b>Charles W. Fletcher Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Nichols</b>											
19a. Informant's Name/Relationship (Type, Print) <b>Mr. &amp; Mrs. Fletcher Jr. Parents</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2545 Arunah Ave. Balto. MD. 21216</b>											
20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>11/30/00</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>							
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Injuries</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown					
										24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>											
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>11/25/00</b>		28b. Time of Injury <b>0008 HR</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject pedestrian struck by vehicle</b>							
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>roadway</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2400 block Edmondson &amp; Whitmore Avenue Baltimore Maryland</b>											
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>November 25, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature <i>[Signature]</i>											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38383

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>MARY GRACE FINK</b>				2. Date of Death Month Day Year <b>NOVEMBER 28, 2000</b>		3. Time of Death <b>7:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>HOMESTEAD MANOR ASSISTED LIVING</b>				4b. City, Town, or Location of Death <b>DENTON</b>		4c. County of Death <b>CAROLINE</b>	
5. Social Security Number <b>243-01-9973</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 18, 1910</b>	
9. Birthplace (State or Foreign Country) <b>NC</b>		Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>CAROLINE</b>		10c. City, Town or Location <b>DENTON</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>410 COLONY DRIVE</b>		10f. Zip Code <b>21629</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>CLOTHING</b>			
17. Father's Name (First, Middle, Last) <b>WILLIAM J. LLOYD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAMIE LLOYD</b>			
19a. Informant's Name/Relationship (Type, Print) <b>RICHARD B. FINK, SR. (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>667 BAY GREEN DRIVE, ARNOLD, MARYLAND 21012</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		20c. Location - City or Town, State <b>12/2/2000 GLEN BURNIE, MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			

To Be Completed by Funeral Director

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
a. <b>Alzheimer's Dementia, Probable 5 yrs</b> Due to (or as a consequence of):			
b. Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CNF, HTN</b>		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
---	--	---	--	---	--

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
---	--

29b. Signature and title of certifier 		29c. License number <b>D0053255</b>		29d. Date signed (Month, Day, Year) <b>11/29/2000</b>	
---	--	--	--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Melinda Butler 215 Bloomingdale Ave Federalsburg MD 21632</b>	
--	--

31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 	
--	--	-------------------------------	--

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38384

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERTRUDE FRIEDMAN</b>				2. Date of Death Month Day Year <b>NOVEMBER 30, 2000</b>				3. Time of Death <b>3:00PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>OASYS ASSISTED LIVING</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>				4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>216-07-7879</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>FEB. 25, 1910</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>COLUMBIA</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9359 GUILFORD ROAD</b>		10f. Zip Code <b>21046</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESWOMAN</b>		16b. Kind of Business/Industry <b>HECHT COMPANY</b>		17. Father's Name (First, Middle, Last) <b>LOUIS FRIEDMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA CHASANOV</b>		
19a. Informant's Name/Relationship (Type, Print) <b>LARRY CARSON / NEPHEW</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7168 WINTER ROSE PATH - COLUMBIA, MD 21045</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BNAI ISRAEL CEMETERY</b>		20c. Location - City or Town, State <b>12/3/00 BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Sepsis</b> Due to (or as a consequence of): b. <b>pneumonia</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>Hours</b> <b>Days</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D36786</b>		29d. Date signed (Month, Day, Year) <b>12-1-00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey KATZ 126528 Ocean Shore Lane, Columbia, MD 21044-6070</b>		31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 35 AM 8:32

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38385

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith M. Green

2. Date of Death

Month

Day

Year

11

28

00

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

501E. Preston St. apt.302

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

219-18-3359

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/09/1912

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 E. Preston St.

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give X  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

St. Agnes Hosp

17. Father's Name (First, Middle, Last)

Jessie Parker

18. Mother's Name (First, Middle, Maiden Surname)

Rose Murry

19a. Informant's Name/Relationship (Type, Print)

Rosa Fields (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1611N. Caroline St. Balto. Md. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arbutus Mem.

Date

12/06/00

20c. Location - City or Town, State

Arbutus, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Betts Funeral Home

1129 N. Caroline St. Balto. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Carcinoid tumor of rectum

Approximate  
Interval Between  
Onset and Death

3 years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Marc Sokolow, M.D. Attending Physician

D 26 534

12/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc Sokolow, M.D. 301 St. Paul Place Baltimore, MD 21202

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

J. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38386

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

David Michael Gardner

2. Date of Death

November 30, 2000

3. Time of Death

2:08 pm

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

547-48-0646

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 7, 1937

9. Birthplace (State or Foreign Country)

Japan

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3569 Ft. Meade Road # 203

10f. Zip Code

20724

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Grade 12College (1-4 or 5+)  
4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Public Affairs (Major)

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

James Gardner

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Tomasovich

19a. Informant's Name/Relationship (Type, Print)

Delores Spicer / Life Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3569 Ft. Meade Road #203 Laurel, Maryland 20724

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

Dec. 11, 2000

20c. Location - City or Town, State

Catonsville, Md.

21. Signature of Funeral Service Licensee

/M00770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Avenue Laurel, Maryland 20707

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure / ventilator dependence

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D01852

29d. Date signed (Month, Day, Year)

November 30 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20782

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38387

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ella K. Gassaway						2. Date of Death Month Day Year DEC. 4, 2000		3. Time of Death 4:40am	
	4a. Facility Name (If not institution, give street and number) Hammonds Lane Nursing Center						4b. City, Town, or Location of Death Baltimore		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-26-4662		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) AUG 1, 1916		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Severna Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 7 Riverview Road				10f. Zip Code 21146		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Unk.						18. Mother's Name (First, Middle, Maiden Surname) Unk.				
19a. Informant's Name/Relationship (Type, Print) William Gassaway/son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Riverview Road Severna Park, MD 21146				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State Baltimore, MD		20d. Date 12/4/00		
21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228						
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIAC ARITHMIA										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Dawn F. McDonald				29c. License number D 21776			29d. Date signed (Month, Day, Year) DECEMBER 4 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUREA MUNDRA MD 3001 S HANOVER ST BALTIMORE 21225										
31. Date filed (Month, Day, Year) DEC 5 2000				32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



jhm  
CONSTANTINO  
GEORGIADIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38388

amend item 23a,27,28a,bc,de,f per me G790 12/6/00

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Konstantinos Georgiadis				2. Date of Death Month Day Year NOVEMBER 28, 2000		3. Time of Death 23:26 PM	
	4a. Facility Name (If not institution, give street and number) 1000 FELL STREET APARTMENT 614				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number Unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 10, 1958	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
10a. State New Jersey		10b. County Bergen		10c. City, Town or Location Glen Rock		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 40 Leone Court				10f. Zip Code 07452		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Associate		16b. Kind of Business/Industry Real Estate		
17. Father's Name (First, Middle, Last) George Georgiadis				18. Mother's Name (First, Middle, Maiden Surname) Argere Kanellis				
19a. Informant's Name/Relationship (Type, Print) Argere Georgiadis - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Leone Court, Glen Rock, NJ 07452				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fair Lawn Memorial Cem.		Date Dec. 2		20c. Location - City or Town, State Fair Lawn, NJ		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 11/28/00		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) apartment		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1000 Fells St., Baltimore, Md				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) NOVEMBER 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) DEC - 5 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38389

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florinda E. Horner				2. Date of Death Month Day Year December 4, 2000				3. Time of Death 8:45 a.m.	
	4a. Facility Name (If not institution, give street and number) Ivy Hall Geriatric Center				4b. City, Town, or Location of Death Middle River				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-01-9294		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) July 29, 1917		9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore	
To Be Completed by Funeral Director	10c. City, Town or Location Essex				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1000 Franklin Avenue	
	10f. Zip Code 21221				10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House wife				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Frank Corrieri				18. Mother's Name (First, Middle, Maiden Surname) Camilla Webster				19a. Informant's Name/Relationship (Type, Print) LeRoy Horner (son)	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4218 Necker Avenue, Baltimore, Maryland 21236				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery	
	20c. Date 12/7/2000				20d. Location - City or Town, State Baltimore, Maryland				21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia				Approximate Interval Between Onset and Death one wk	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy, DM, HTN, Osteoporosis				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier M.D.		
29c. License number D-38754				29d. Date signed (Month, Day, Year) 12-04-2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASEEM, 709. EASTERN BLVD, MD - 21221		
31. Date filed (Month, Day, Year) DEC 05 2000				32. Registrar's Signature 				State Registrar		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38390

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edna Holland</b>				2. Date of Death Month Day Year <b>Dec. 02, 2000</b>				3. Time of Death <b>5:54pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>216-34-5235</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>09-19-38</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>1403 Myrtle Avenue</b>				10f. Zip Code <b>21217</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High Sch. Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing</b>				16b. Kind of Business/Industry <b>Private Duty</b>		
17. Father's Name (First, Middle, Last) <b>Sylvester White</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Geneva White</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Khadija Sims</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21217</b> <b>1403 Myrtle Avenue Baltimore, Maryland</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem. 12-06-2000 Randallstown, MD</b>				20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung cancer</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  <b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b>  <b>23b. Did tobacco use contribute to the cause of death?</b> <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>  <b>24a. Was an autopsy performed?</b> <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  <b>25. Was case referred to medical examiner?</b> <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  <b>26. Place of Death (Check only one)</b> Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>  <b>27. Manner of Death</b> 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  <b>28a. Date of Injury (Month, Day, Year)</b> <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>  <b>29a. Certifier (Check only one)</b> <b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  <b>29b. Signature and title of certifier</b> <b>29c. License number</b> <b>29d. Date signed (Month, Day, Year)</b>  <b>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)</b> <b>Helen Gordon MD 6601 N. Charles St Baltimore MD 21204</b>  <b>31. Date filed (Month, Day, Year)</b> <b>DEC 5 2000</b> <b>32. Registrar's Signature</b> <b>[Signature]</b>										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38391

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Agnes Haney</b>				2. Date of Death Month Day Year <b>Dec. 02, 2000</b>				3. Time of Death <b>0146 am</b>					
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>					
Funeral Director	5. Social Security Number <b>212-30-4563</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>04-19-22</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
	10e. Street and Number <b>1040 Reverdy Road</b>				10f. Zip Code <b>21212</b>				10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School System</b>				16b. Kind of Business/Industry <b>Baltimore City Sch.</b>					
	17. Father's Name (First, Middle, Last) <b>James Henson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Jones</b>									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Seaton Haney</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>847 Reverdy Road Baltimore, Maryland 21212</b>									
	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>				20c. Location - City or Town, State <b>MD</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of): <b>b. Alzheimer's dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death <b>weeks</b> <b>years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>00051926</b>				29d. Date signed (Month, Day, Year) <b>December 2, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Helen Gordon MD 6601 N. Charles St, Baltimore MD 21204</b>													
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38392

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John L. Harris</b>				2. Date of Death Month Day Year <b>Nov. 29, 2000</b>				3. Time of Death <b>0712am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Baltimore Veterans Administration</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>243-24-8586</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01-17-26</b>		9. Birthplace (State or Foreign Country) <b>SC</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>847 Glenwood Avenue</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Blast Furnace Operator</b>		16b. Kind of Business/Industry <b>Bethlehem Steel Co</b>				
17. Father's Name (First, Middle, Last) <b>John H. Harris</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Henderson</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Edna M. Harris</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>847 Glenwood Avenue Baltimore, Maryland 21212</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem.</b>		20c. Date <b>12-06-2000</b>		20d. Location - City or Town, State <b>MD. Owings Mill</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Aspiration Pneumonia</b> Due to (or as a consequence of): b. <b>Malnutrition</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>history of esophageal cancer with esophageal resection and gastric pull-up in hospital for malnutrition and jejunostomy tube placement</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  <b>Morgan McCullough MD (Resident Physician)</b>				29c. License number <b>P4292</b>		29d. Date signed (Month, Day, Year) <b>12/5/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Morgan McCullough Baltimore VA Hospital Baltimore, MD 21201</b>										
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38393

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Theodore Hopkins

2. Date of Death

Month 11

Day 27

Year 2000

3. Time of Death

3:54 PM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

218-12-8681

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 21, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3918 Yolando Road

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Garage Attendant

16b. Kind of Business/Industry

Hutzler Bros. Corp.

17. Father's Name (First, Middle, Last)

Ulysses Hopkins

18. Mother's Name (First, Middle, Maiden Surname)

Marie Hopper

19a. Informant's Name/Relationship (Type, Print)

Ralph Underwood-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3918 Yolando Rd., Balto., MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

12/2

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Ernest R. Ferry

22. Name and Address of Facility

Nutter Funeral Home Inc.

2501 Gwynns Falls Pkwy. Balto. MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Due to (or as a consequence of):

b. Urinary Tract Infection Due to (or as a consequence of):

c. Neurogenic Bladder Due to (or as a consequence of):

d. Spinal Cord Injury

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ernest R. Ferry

29c. License number

D 53283

29d. Date signed (Month, Day, Year)

11/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1147 South Hancock Street Baltimore MD 21230

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

Ernest R. Ferry

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



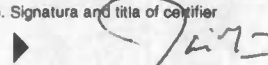
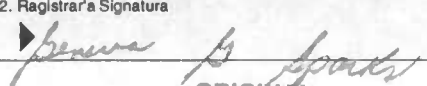
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38394

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUELLA KATHRYN CHILDS HODGES</b>				2. Date of Death Month Day Year <b>Nov. 30 2000</b>				3. Time of Death <b>2:15AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore County</b>				4c. County of Death <b>Baltimore</b>			
Funeral Director	5. Social Security Number <b>212-12-6254</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-20-1909</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore County</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>104 Elinor Avenue</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>1 yr.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Coder</b>			16b. Kind of Business/Industry <b>Baltimore County Police Dept.</b>				
	17. Father's Name (First, Middle, Last) <b>Jacob Everett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estella J. Wills</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Eileen I. Grueninger (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8510 Harris Avenue Baltimore, Maryland 21234</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>12-4-00</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Other: _____		29b. Signature and title of certifier 				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>12/1/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093</b>											
State Registrar	31. Date filed (Month, Day, Year) <b>DEC - 5 2000</b>		32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38395

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES A. HENKEL</b>		2. Date of Death Month: <b>NOVEMBER</b> Day: <b>28</b> Year: <b>2000</b>		3. Time of Death <b>2:40 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>8275 LAKE WATERFORD ROAD</b>		4b. City, Town, or Location of Death <b>PASADENA</b>		4c. County of Death <b>ANNE ARUNDEL</b>
Funeral Director	5. Social Security Number <b>214-14-0114</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 21, 1921</b>
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>				
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>PASADENA</b>
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>8275 LAKE WATERFORD ROAD</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4 or 5+) <b>HOMEMAKER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>
	17. Father's Name (First, Middle, Last) <b>ROBERT L. HALL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA HERBERT</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>ROBERT L. HENKEL (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8275 LAKE WATERFORD ROAD, PASADENA, MD. 21122</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Congestive heart failure</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cellulitis</b> <b>Pneumonia</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>NOV 28 2000</b>		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		
	29c. License number <b>D 23624</b>		29d. Date signed (Month, Day, Year) <b>NOV 28, 2000</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1600 Scrain Hwy Suite 306 Glen Burnie MD 21061</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38396

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Dorothy Huggins</u>				2. Date of Death Month <u>December</u> Day <u>03</u> Year <u>2000</u>		3. Time of Death <u>03 44</u>	
	4a. Facility Name (If not institution, give street and number) <u>Mercy Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore, MD</u>		4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>220-62-3088</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>51</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Mar. 21, 1949</u>	
	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		10a. State <u>MD.</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <u>2021 E. LOMBARD STREET</u>				10f. Zip Code <u>21231</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>American Indian</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEWIFE</u>		16b. Kind of Business/Industry <u>DOMESTIC</u>			
	17. Father's Name (First, Middle, Last) <u>MAJOR P. FELTS</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>CORA COLEY</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>LISA HUGGINS/ DAUGHTER</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2021 E. LOMBARD STREET, BALTIMORE, MARYLAND 21231</u>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>CEDAR HILL CEMETERY</u>		20c. Location - City or Town, State <u>12/7/00 BALTIMORE, MARYLAND</u>			
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>LILLY &amp; ZEILER INC. FUNERAL HOME</u> <u>1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic cancer of unknown primary</u> Due to (or as a consequence of): b. <u></u> Due to (or as a consequence of): c. <u></u> Due to (or as a consequence of): d. <u></u> Approximate Interval Between Onset and Death <u>Unknown</u>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred <u></u>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u>			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <u>[Signature] MD</u>				29c. License number <u>P12507</u>		29d. Date signed (Month, Day, Year) <u>December 03, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Daniel Weiner, Dept of Medicine 301 St Paul Place Baltimore, MD 21201</u>							
	31. Date filed (Month, Day, Year) <u>DEC 4 2000</u>				32. Registrar's Signature <u>[Signature]</u>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38397

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOSEPH HERTZ</b>		2. Date of Death Month Day Year <b>December 01 2000</b>		3. Time of Death <b>11:24 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-18-8679</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>DEC.14,1908</b>		9. Birthplace (State or Foreign Country) <b>N.Y.</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6956 MILBROOK PARK DRIVE #1B</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TICKET SELLER</b>		16b. Kind of Business/Industry <b>RACING</b>	
17. Father's Name (First, Middle, Last) <b>BARNETT</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE BENDERSKY</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LOUIS BENDER / COUSIN</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9818 MICHAELS WAY - ELLICOTT CITY, MD 21042</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SHAAREI TFILOH CEMETERY</b>		20c. Location - City or Town, State <b>WOODLAWN, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dilated cardiomyopathy</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Karen Weber DO</b>		29c. License number <b>RES-000</b>	
		29d. Date signed (Month, Day, Year) <b>December 01, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Karen Weber, D.O. Sinai Hospital of Baltimore</b>					
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38398

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FANNY S. HESS

2. Date of Death

Month

Day

Year

DECEMBER

1<sup>ST</sup> 2000

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-44-5958

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUN. 14, 1898

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4001 OLD COURT ROAD #316

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SOL

SCHLEISNER

18. Mother's Name (First, Middle, Maiden Surname)

VIOLET

MAYER

19a. Informant's Name/Relationship (Type, Print)

LEWIS M. HESS, JR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4001 OLD COURT ROAD #316 - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OHEB SHALOM MEMORIAL PARK 12/3/00 REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

10 YRS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. END STAGE DEMENTIA

Due to (or as a consequence of):

10 YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anna M. Eversley M.D.

29c. License number

D 54739

29d. Date signed (Month, Day, Year)

DECEMBER 1<sup>ST</sup> 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W. Belvedere Avenue, Baltimore Maryland 21215

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, HESS, FANNY





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38399

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

KENNETH DAVID HAINES

2. Date of Death

December 02, 2000

3. Time of Death

6:10 P.M.

4a. Facility Name (If not institution, give street and number)

Hunting Area off Brown Road

4b. City, Town, or Location of Death

Wolfsville

4c. County of Death

Frederick

5. Social Security Number

187-48-4088

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 7, 1959

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

ADAMS

10c. City, Town or Location

FAIRFIELD, PA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 IVY TRAIL

10f. Zip Code

17320

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: ARMY RESERVE

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFSET PRESS OPER.

16b. Kind of Business/Industry

PRINTING Co.

17. Father's Name (First, Middle, Last)

GEORGE S. HAINES, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ZOE E. HAINES

19a. Informant's Name/Relationship (Type, Print)

MARTHA HAINES / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 IVY TRAIL, FAIRFIELD, PA. 17320

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FAIRFIELD UNION CEM.

Date

12/6/00

20c. Location - City or Town, State

FAIRFIELD, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
HARTLEY MILLER FUNERAL HOME  
FOR MONAHAN FUNERAL HOME  
7527 HAF FORD Rd. BALTO MD. 21234

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 04, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THE MONTE McKenney

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

DEC - 5 2000

Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Medical Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38400

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICA JONES</b>				2. Date of Death Month <b>NOVEMBER</b> Day <b>29</b> , Year <b>2000</b>				3. Time of Death <b>3:00am</b>	
	4a. Facility Name (If not institution, give street and number) <b>3700 HILLSDALE AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-74-4915</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>40</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>1-5-1960</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON, DC</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3700 HILLSDALE AVE.</b>				10f. Zip Code <b>21207</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4or 5+) <b>-4-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROBATION OFFICER</b>				16b. Kind of Business/Industry <b>U.S. DISTRICT COURT</b>		
17. Father's Name (First, Middle, Last) <b>CALVIN JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>THELMA MORSELL</b>						
19a. Informant's Name/Relationship (Type, Print) <b>JACQUELINE JONES(SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3460 OLD BAYSIDE RD. CHESAPEAKE BEACH, MD 20732</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ERNESTINE JONES CEMETERY</b>		Date <b>12-4-2000</b>		20c. Location - City or Town, State <b>CHESAPEAKE, MD.</b>				
21. Signature of Funeral Service Licensee <i>Spencer Sewell</i>				22. Name and Address of Facility <b>SEWELL FUNERAL HOME</b> <b>1451 DARES BEACH RD. PRINCE FREDERICK, MD. 20678</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Adrenal Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>20 months</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Samuel Denmeade MD</i>				29c. License number <b>D44576</b>				29d. Date signed (Month, Day, Year) <b>11/30/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Samuel Denmeade 1650 Orleans St Baltimore MD 21231</b>										
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature <i>Sparks</i>								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38401

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIAN V KUTZERA</b>				2. Date of Death Month <b>December</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>8:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Nursing Home</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>213-24-3775</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Mar 12, 1928</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Laurel</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>704 A Montgomery Street</b>				10f. Zip Code <b>20707</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesclerk</b>		16b. Kind of Business/Industry <b>Department Store</b>	
	17. Father's Name (First, Middle, Last) <b>Ace Childers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Eugenia Liller</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Donald Kutzera /spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7901 Laurel Lakes Ct. Apt 111, Laurel, MD 20707</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Cemetery</b>		Date <b>12/5/00</b>	20c. Location - City or Town, State <b>Laurel, Maryland</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. M00773 313 Talbott Avenue, Laurel, MD 20707</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D54853</b>		29d. Date signed (Month, Day, Year) <b>12-01-00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Danny Lee MD, 8317 Cherry Ln, Laurel MD 20707</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38402

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Johann T. Kramm				2. Date of Death Month Day Year December 03, 2000				3. Time of Death 2058 pm		
	4a. Facility Name (If not institution, give street and number) 215 South Bouldin Street				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 058-36-5443		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 73		8. Date of Birth (Month, Day, Year) APR 12, 1927		9. Birthplace (State or Foreign Country) Germany		
	Usual Residence of Decedent										
10a. State Maryland			10b. County N/A			10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 215 South Bouldin Street					10f. Zip Code 21224			10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maitre D'				16b. Kind of Business/Industry Engineering Society Club		
17. Father's Name (First, Middle, Last) Bruno Kramm					18. Mother's Name (First, Middle, Maiden Surname) Paula Renowitzky						
19a. Informant's Name/Relationship (Type, Print) Donna Pell/Friend					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 Paulette Rd. Apt #3 Baltimore, MD 21222						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.			Date 12-4-00		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Edward A. Gregorchik					22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CANCER								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Dennis J. Chute M.D.					29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) December 04, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC 5 2000			32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#9 PER F.H. G790 12-5-2000 JAB

Certificate of Death

Reg. No.

00 38404

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JACOB

M.

KULEFSKY

2. Date of Death

Month  
NovemberDay  
30Year  
2000

3. Time of Death

1124 pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-36-8701

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC.15,1925

9. Birthplace (State or Foreign Country)

IL.

HIT

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

401 YESHIVA LANE #2A

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DEAN

16b. Kind of Business/Industry

COLLEGE  
NER ISRAEL RABBINICAL

17. Father's Name (First, Middle, Last)

NATHAN

KULEFSKY

18. Mother's Name (First, Middle, Maiden Surname)

ROCHEL

WALDMAN

19a. Informant's Name/Relationship (Type, Print)

SARAH KULEFSKY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 YESHIVA LANE #2A - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

AGUDATH ISRAEL CEMETERY

Date

12/1/00

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

November 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN H. GAULT MD

SINAI HOSPITAL

2401 WEST BELVEDERE AVENUE

BALTIMORE, MARYLAND 21215

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

[Signature]

State  
Registrar

PATIENT KNOWN AS JACOB M KULEFSKY

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38405

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Alfred Lyman				2. Date of Death Month Day Year December 3 2000				3. Time of Death 3:00 PM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 324-16-7501		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) NOV 8, 1924		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 226 Beech View Court				10f. Zip Code 21286				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer				16b. Kind of Business/Industry Westinghouse		
17. Father's Name (First, Middle, Last) Franklin Alfred Lyman				18. Mother's Name (First, Middle, Maiden Surname) Janet Birrell						
19a. Informant's Name/Relationship (Type, Print) Mary Jane Lyman/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Beech View Court Towson, MD 21286						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Date 12-4-00		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. mesothelioma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death years										
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of certifier W.A. Riley, MD				29c. License number 225205				29d. Date signed (Month, Day, Year) December 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, MD 16701 N. Charles St. Balto. md 21204										
31. Date filed (Month, Day, Year) DEC 5 2000				32. Registrar's Signature B. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38406

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Lynch				2. Date of Death Month Day Year December 1, 2000				3. Time of Death 6:05 PM	
	4a. Facility Name (If not institution, give street and number) Mariner Health				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 219-05-6911		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) June 30, 1921		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10c. City, Town or Location Glen Burnie		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel		10e. Street and Number 7355 Furnace Branch Road				10f. Zip Code 21060	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Veterinarian Assistant				16b. Kind of Business/Industry Animal Hospital	
	17. Father's Name (First, Middle, Last) Edward Willey				18. Mother's Name (First, Middle, Maiden Surname) Olga Smith					
	19a. Informant's Name/Relationship (Type, Print) Eleanor R. Sanderson - Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 296 Creek Blvd., Pasadena, MD 21122					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date Dec. 4		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction				Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Due to (or as a consequence of):					
	Due to (or as a consequence of):				Due to (or as a consequence of):					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Laween Laleham		29c. License number D28595		29d. Date signed (Month, Day, Year) 12/4/00			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) IASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALTO MD									
	31. Date filed (Month, Day, Year) DEC 05 2000		32. Registrar's Signature B Sparks							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38407

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ZELDA K. LEVIN</b>				2. Date of Death Month Day Year <b>NOVEMBER 28, 2000</b>		3. Time of Death <b>10:40PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BRIGHTWOOD NURSING HOME</b>				4b. City, Town, or Location of Death <b>LUTHERVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-38-2482</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 27, 1909</b>	9. Birthplace (State or Foreign Country) <b>VA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>7211 PARK HEIGHTS AVENUE #303</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DENTAL OFFICE MANAGER</b>			16b. Kind of Business/Industry <b>DENTISTRY</b>	
	17. Father's Name (First, Middle, Last) <b>PHILIP KLOMPUS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MOLLY TUMBLER</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JULES LEVIN / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 STAGS LEAP COURT - BALTIMORE, MD 21208</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP CEMETERY</b>		20c. Date <b>12/1/00</b>		20d. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Dehydration</i> Due to (or as a consequence of): b. <i>Dementia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <i>2-3 weeks</i> <i>1 year</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitel: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Date signed (Month, Day, Year) <b>11/29/00</b>			
	29. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Elliot Rothschild</i> MD				29c. License number <b>051426</b>		29d. Date signed (Month, Day, Year) <b>11/29/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elliot Rothschild 4000 Old Court Rd, Pikesville, MD 21208</b>								
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>				32. Registrar's Signature <i>Sparks</i>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38408

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Leroy Loggins</b>				2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>1:45 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1207 Harwood Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-14-9911</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 11, 1907</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1207 Harwood Ave.</b>		10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Musician</b>		16b. Kind of Business/Industry <b>Self Employed</b>				
17. Father's Name (First, Middle, Last) <b>Bradley Loggins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Owings</b>				
19a. Informant's Name/Relationship (Type, Print) (Nephew) <b>Mr. Ernest W. Loggins</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9835 Winands Rd. Randallstown, Md. 21133</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Location - City or Town, State <b>Owings Mills, Md.</b>		20d. Date <b>12/6/2000</b>		
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>moderate left ventricle dysfunction</b> Due to (or as a consequence of): b. <b>Transient Ischemic Attack</b> Due to (or as a consequence of): c. <b>Sick sinus syndrome status post pacemaker</b> Due to (or as a consequence of): d. <b>Chronic obstructive pulmonary disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Left parotid mass</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Joseph L. Russ MD</b>				29c. License number <b>D 31464</b>		29d. Date signed (Month, Day, Year) <b>11/30/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STONIA A. HASHIM, 821 N. EYTAW St Suite 30F, Balt. MD 21201</b>								
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

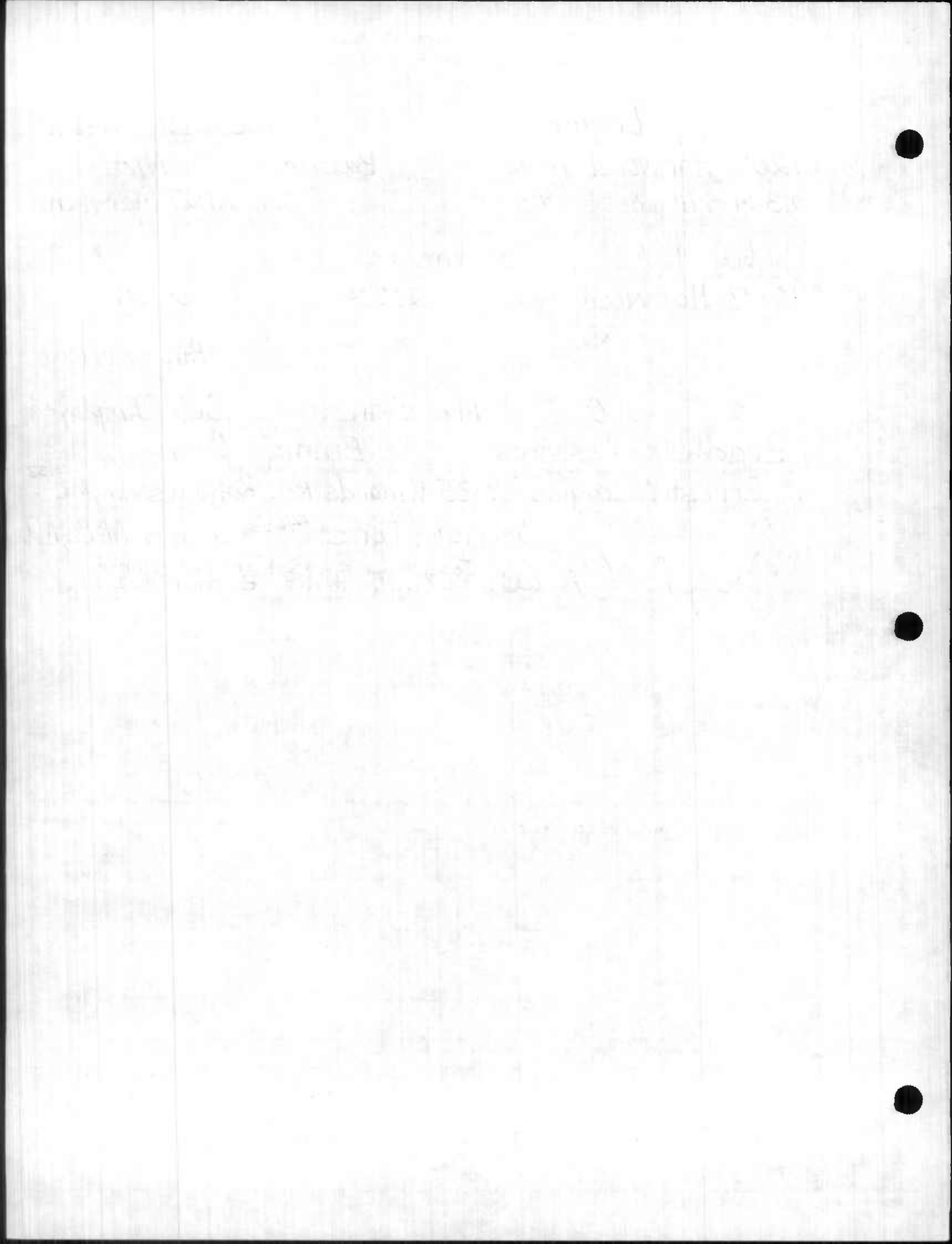
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38409

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Estelle Morris</b>				2. Date of Death Month <b>November</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>1450</b>		
	4a. Facility Name (If not institution, give street and number) <b>St. Agnes Hosp.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>		
Funeral Director	5. Social Security Number <b>219-30-7188</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/17/1935</b>		
	10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>2704 Fenwick Ave.</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+) <b>n/a</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Housekeeper</b>		16b. Kind of Business/Industry <b>G.B.M.C.</b>			
17. Fether's Name (First, Middle, Last) <b>Walter Hayes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Frozer</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Arlene Gray</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>55 S. Kukui St. Honolulu, HI</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cem.</b>		20c. Location - City or Town, State <b>12/8/00 Baltimore Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Betts Funeral Home 1129 N. Caroline St. Baltimore Md. 21213</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. GI Bleed (Gastrointestinal)</b> Due to (or as a consequence of): <b>b. Diverticular Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 hour</b> <b>10 year</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure, Diabetes, Peripheral vascular Disease, Hypertension</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>365848998</b>		29d. Date signed (Month, Day, Year) <b>November 30, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Greenwald St Agnes Hospital Baltimore Md. 21229</b>									
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

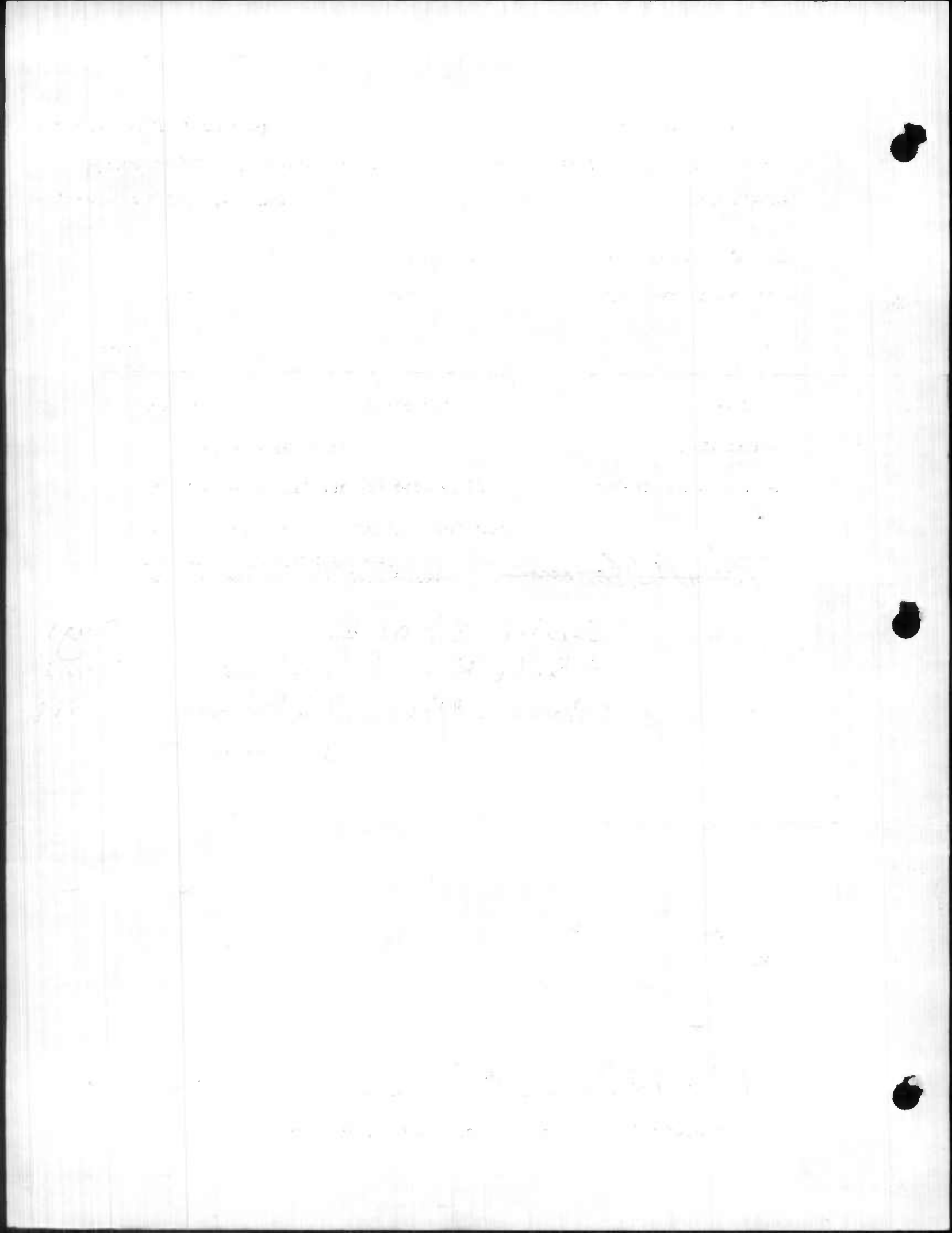
00 38410

AMEND ITEMS: #21,22 PER F.H. G790 12-5-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lucretia Mae Martin				2. Date of Death Month Day Year September 7, 2000		3. Time of Death 2:50PM	
	4a. Facility Name (If not Institution, give street and number) Fort Washington Medical Center				4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 245-20-1949		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 12, 1925	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Fort Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1115 Palmer Road, Apt. 6		10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Garment			
	17. Father's Name (First, Middle, Last) Walter Cherry				18. Mother's Name (First, Middle, Maiden Surname) Ronita Dell Davis			
	19a. Informant's Name/Relationship (Type, Print) Joseph C. Martin-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 432 Halsted Street, East Orange, NJ 07018			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Lawn Cemetery		20c. Location - City or Town, State 9/16/00 Norfolk, VA			
	21. Signature of Funeral Service Licensee BEVERLY GROMARTIE per DVR				22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST. P.O. THOMASSON FUNERAL SVS., INC. BALTO, MD 21213 4456 BONNEY ROAD, VA BCH, VA 23462			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Acute Renal Failure Due to (or as a consequence of): c. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): d. Days Days years							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier A.M. Ali		29c. License number D46046		29d. Date signed (Month, Day, Year) 9-8-00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Amir Alikhani, 118 Lagrange Road, LaPlata, MD 20646								
31. Date filed (Month, Day, Year) DEC 5 2000		32. Registrar's Signature Beverly G. Sparks						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38411

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Lola Bonnie Moore</b>		2. Date of Death Month <b>December</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>7:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>18 Mitchell Road</b>		4b. City, Town, or Location of Death <b>Middle River</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>193-22-1117</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>June 1, 1928</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>18 Mitchell Road</b>		10f. Zip Code <b>21220</b>	
10g. Citizen of What Country? <b>U. S. A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Homemaker</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Blane Coburan</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Saucer</b>		19a. Informant's Name/Relationship (Type, Print) <b>Wilbur Clyde Moore (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Mitchell Road Middle River, MD 21220</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gard.</b>		20c. Location - City or Town, State <b>Middle River, MD</b>	
21. Signature of Funeral Service Licensee <i>Michael C. Jefferson</i> M-00938		22. Name and Address of Facility <b>Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, MD 21221</b>		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>STAGE IV Bronchogenic CANCER of the Lung 6ms</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>PHM</i>		29c. License number <b>H54913</b>	
29d. Date signed (Month, Day, Year) <b>12/1/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PROSPER SANCHEZ, D.O 404 EASTERN BLVD BALTIMORE, MD 21221</b>		31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>	
32. Registrar's Signature <i>Sparks</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38412

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Juanita Miller

2. Date of Death

Month

Day

Year

December 2 2000

6:08 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

212-46-2529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 24, 1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3 Eyring Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Oakie Belle

18. Mother's Name (First, Middle, Maiden Surname)

Cora

Unknown

19a. Informant's Name/Relationship (Type, Print)

Linda Simmons (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1514 South Hanover Street, Baltimore, Maryland 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

12/6/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22503

29d. Date signed (Month, Day, Year)

12/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jahangir Khan MD 9000 Franklin Square Drive Baltimore Maryland 21237

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

S. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-343-0024.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38413

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pearleen Marcus</b>				2. Date of Death Month Day Year <b>Dec. 01, 2000</b>				3. Time of Death <b>8:04am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>243-26-7721</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08-13-15</b>		9. Birthplace (State or Foreign Country) <b>NC</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>340 East 22nd. Street</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dietary</b>				16b. Kind of Business/Industry <b>Fort Meade</b>		
17. Father's Name (First, Middle, Last) <b>Luther Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Anderson</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Katie Emanuel</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21218</b> <b>340 East 22nd. Street Baltimore, Maryland</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cemetery 12-07-2000 Randallstown</b>				20c. Location - City or Town, State <b>MD</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cardiac arrest</b> Due to (or as a consequence of):  b. <b>Coronary artery disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>30 minutes</b>  <b>years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes, insulin dependent, Hypertension, Cerebrovascular disease, hypercholesterolemia</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>D0056215</b>		29d. Date signed (Month, Day, Year) <b>December 4, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Melinda Bard, MD 2323 Orleans St Baltimore MD 21224</b>										
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38414

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Johnnie Lee Miller</b>		2. Date of Death Month Day Year <b>NOV. 29 2000</b>		3. Time of Death <b>12:57 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS (BAYVIEW) HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>216-40-2123</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>NOV. 25, 1942</b>		9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>4915 ABERDEEN AVENUE</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th GRADE</b> College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>AMERISTEEL CUTTER</b>		16b. Kind of Business/Industry <b>AMERISTEEL COMPANY</b>		
	17. Father's Name (First, Middle, Last) <b>MACKIE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MILLER HATTIE BRUNSON</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>DELORES MILLER (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4915 ABERDEEN AVE., BALTIMORE, MD. 21206</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>		20c. Location - City or Town, State <b>12-5-00 BALTIMORE, MARYLAND</b>
	21. Signature of Funeral Service Licensee <b>N. W. Williams</b>		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 3140 N. FULTON AVE., BALTIMORE, MD. 21217</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Non small cell lung cancer</b> Due to (or as a consequence of):  b. <b>Smoking</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death <b>8   00</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <b>Michael Fingerhut</b>
29c. License number <b>D35761</b>		29d. Date signed (Month, Day, Year) <b>12/4/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Fingerhut Johns Hopkins Bayview Medical Center Baltimore MD 21224</b>					
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature <b>Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38415

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISAAC MCCAULEY				2. Date of Death Month Day Year NOV - 28 - 00		3. Time of Death 1:10 AM	
	4a. Facility Name (If not institution, give street and number) ST AGNES HEALTH CARE, 900 CATON AVE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-52-9705	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DECEMBER 26, 1952		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 3907 GLEN AVENUE			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years of college		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry BALTIMORE CITY Public Schools			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ABRAHAM MCCAULEY			18. Mother's Name (First, Middle, Maiden Surname) LUVENIA FELDER				
	19a. Informant's Name/Relationship (Type, Print) LUVENIA MCCAULEY (mother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 588 YALE AVE., BALTIMORE, MARYLAND 21229				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		20c. Location - City or Town, State BALTIMORE, MARYLAND		20d. Date 12-2-00	
	21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROSTATE CARCINOMA WITH METASTASIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death MTHS - YEARS
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier [Signature]			29c. License number P-14445		29d. Date signed (Month, Day, Year) 11/28/00		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANISH PANDYA, MD, 900 CATON AVE, BALTIMORE, MD-21229							
	31. Date filed (Month, Day, Year) DEC 05 2000		32. Registrar's Signature [Signature]					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38416

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hyacinth Elizabeth McBride</b>				2. Date of Death Month <b>November</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>10:47 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>824 North Bentalou Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-12-7707</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 6, 1911</b>		
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) <b>12th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>				16b. Kind of Business/Industry <b>Private Duty</b>	
17. Father's Name (First, Middle, Last) <b>John H. Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jonathan McBride-Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>824 N. Bentalou St., Balto. MD 21216</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 11/29 Baltimore, MD</b>				20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <b>Inspection</b> <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>					
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <b>1</b> <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>November 21, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature 					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38417

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Athenia Marks-McDonald</b>			2. Date of Death Month Day Year <b>NOV 28 00</b>		3. Time of Death <b>12:45P</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST AGNES HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-86-9024</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>32 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Mar. 21, 1968</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>4022 Glen Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Postal Mail Handler</b>		16b. Kind of Business/Industry <b>U.S. Postal Service</b>		
	17. Father's Name (First, Middle, Last) <b>Wendell Augustus Smith</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Marks</b>		19a. Informant's Name/Relationship (Type, Print) <b>Kenneth McDonald-husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4022 Glen Ave. Balto. MD 21215</b>
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>12/5 Balto, MD</b>		
	21. Signature of Funeral Service Licensee <b>Herbert E. Nutter</b>		22. Name and Address of Facility <b>Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>METASTATIC GASTRIC CARCINOMA</b> Due to (or as a consequence of): b. <b>PANCYTOPENIA</b> Due to (or as a consequence of): c. <b>FUNGEMIA</b> Due to (or as a consequence of): d. <b>RENAL FAILURE</b>		Approximate Interval Between Onset and Death <b>2 MON</b> <b>1 WEEK</b> <b>2 WEEKS</b> <b>1 WEEK</b>
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Sapna Kuehl</b>		29c. License number <b>M50126</b>		29d. Date signed (Month, Day, Year) <b>NOV 30/00</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SAPNA KUEHL, MD BOX 060 ST AGNES HOSPITAL</b>		31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38418

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>WAVERLY A. MOSLEY</b>		2. Date of Death Month Day Year <b>DECEMBER 1, 2000</b>		3. Time of Death <b>0031 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death	
5. Social Security Number <b>224-26-5616</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>4-12-24</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>			
10a. State <b>MD.</b>		10b. County		10c. City, Town or Location <b>BALTO.</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2222 PARK AVE.</b>		10f. Zip Code <b>21217</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-46</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK.</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (10-12) <b>10th</b> Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COOK.</b>		16b. Kind of Business/Industry <b>Hospital</b>	
17. Father's Name (First, Middle, Last) <b>GENERAL STEWART MOSLEY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>JENNIE LEE</b>			
19a. Informant's Name/Relationship (Type, Print) <b>DANA MOSLEY</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2222 PARK AVE BALTO. MD. 21217</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>12-6-00 REISTERSTOWN MD.</b>	
21. Signature of Funeral Service Licensee <b>Wesley Chang</b>		22. Name and Address of Facility <b>CHOPIN'S F.H. 2007 EASTERN AVE BALTO. 21231</b>			
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>		24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>11-11-99</b>		28b. Time of Injury <b>M</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dennis J Chute MD</b>		29c. License number <b>OCME</b>	
29d. Data signed (Month, Day, Year) <b>DECEMBER 2, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 7, 8 PER F.H. G790 12-27-00 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38419

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Bessie Melton</b>		2. Date of Death Month Day Year <b>December 3, 2000</b>		3. Time of Death <b>2:30 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>2920 Keswick Road</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>226-09-3100</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06/5/1908</b>
9. Birthplace (State or Foreign Country) <b>N.C. South Carolina</b>					
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2920 Keswick Road</b>			
10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>Spinner</b>			
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Spinner</b>		17. Kind of Business/Industry <b>Mt. Vernon Mill</b>			
18. Father's Name (First, Middle, Last) <b>Ernest Porter</b>			19. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Miller</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JoAnn Seabrease Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>207 Ridge View Drive Davenport, Florida 33837</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial</b>		20c. Location - City or Town, State <b>12/5 Dorsey, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Lynn B. Henss</i>			22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Md 21211</b>		
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal Failure</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c. Diabetes Mellitus</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Betsy A. Fay MD</i>		29c. License number <b>033220</b>		29d. Date signed (Month, Day, Year) <b>12/4/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Betsy FAY MD 3730 FALLS Road Baltimore MD 21211</b>					
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature <i>Betsy A. Fay</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38420

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Thomas Harold Marsh

2. Date of Death

Month Day Year

NOVEMBER 29 2000 11:36 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

287-36-7911

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 25, 1940

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3404 Memphis Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Harold S. Marsh

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Savage

19a. Informant's Name/Relationship (Type, Print)

Geraldine M. Marsh/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3404 Memphis Lane Bowie, MD 20715

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

12-1-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide ☐ Homicide  
☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

041715

29d. Date signed (Month, Day, Year)

11-30-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHITRA VENKATARAMAN MD

6901 GREENBELT ROAD A #3 COLLEGE PARK MD 20740

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38421

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA ANNE MITCHELL

2. Date of Death

November 30 2000 1045AM

3. Time of Death

1045AM

4a. Facility Name (If not institution, give street and number)

401 CALEDONIA AVENUE

4b. City, Town, or Location of Death

HALETHORPE

4c. County of Death

BALTIMORE

5. Social Security Number

217-32-9269

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 23, 1936

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

401 Caledonia Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Housewife &amp; Mother

17. Father's Name (First, Middle, Last)

Charles Hale

18. Mother's Name (First, Middle, Maiden Surname)

Jean Fulton

19a. Informant's Name/Relationship (Type, Print)

Walter B. Mitchell (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 Caledonia Ave., Baltimore, Md. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veteran's Cem. 12/5/00

Date

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee Kevin E Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

237 E. Patapsco Ave., Baltimore, Md.

21225-1856

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *ATHEROSCLEROTIC CARDIOVASCULAR DISEASE*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

E. P. G. M. 711 AMSON RD 401 FREDERICK ROAD CATONSVILLE 21228

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

Beverly G. Sparks

MARYLAND

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38422

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLETTA MCKENZIE</b>				2. Date of Death Month Day Year <b>NOVEMBER 30 2000</b>		3. Time of Death <b>0618 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-56-8226</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>10-8-1949</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10. Usual Residence of Decedent		10a. State <b>MD.</b>		10b. County <b>N/A</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2319 GARRETT AVE.</b>	
	10f. Zip Code <b>21218</b>				10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-12-</b> College (1-4 or 5+) <b>-0-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CASE WORKER</b>		16b. Kind of Business/Industry <b>SOCIAL SERVICE</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>CAROLL FOWLKES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GOERGELLA JESSIE</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>KIM DUKES (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2319 GARRETT AVE. BALTIMORE, MARYLAND 21218</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		20c. Location - City or Town, State <b>12-8-2000 BALTIMORE, MARYLAND</b>	
	21. Signature of Funeral Service Licensee <b>Joath O'Hara</b>				22. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> Due to (or as a consequence of): <b>SPONTANEOUS BACTERIAL PERITONITIS</b> Due to (or as a consequence of): <b>END STAGE RENAL FAILURE</b> Due to (or as a consequence of): <b>HEPATIC FAILURE</b>							Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>2 WEEKS</b> <b>2 WEEKS</b> <b>1 WEEK</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b> <b>HEPATITIS C</b> <b>DIABETES</b> <b>RENAL TRANSPLANT</b>							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Peter Craig, MD</b>			
	29c. License number <b>P14427</b>				29d. Date signed (Month, Day, Year) <b>NOVEMBER 30 2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peter Craig, MD HARBOR HOSPITAL CENTER, 3000 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225</b>				31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>			
	32. Registrar's Signature <b>[Signature]</b>				33. Registrar's Title <b>[Signature]</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM : # 19A PER F.H. G790 State of Maryland / Department of Health and Mental Hygiene 00 38423  
AMEND ITEM: #11 PER F.H. G790 12-28-00 WR. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) May Mirabella				2. Date of Death Month Day Year NOVEMBER 30, 2000				3. Time of Death 3:50 PM		
	4a. Facility Name (If not institution, give street and number) Millennium Health Care & Rehabilitation				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 547-40-0253		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 18, 1919		9. Birthplace (State or Foreign Country) England		
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 616 Sunset Strip				10f. Zip Code 21225		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) William Griffiths				18. Mother's Name (First, Middle, Maiden Surname) Jennie Clee							
19a. Informant's Name/Relationship (Type, Print) Mrs. GEORGINA IRIS MAISH Mrs. Georgia Maish (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8219 Millfield Court, Millersville, Maryland 21108							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Center, LLC				20c. Location - City or Town, State Stevensville, Md.			
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Singleton Funeral Home, P.A., 1 Second Avenue, S.W., Glen Burnie, Md. 21061							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Multi-infarct Dementia Due to (or as a consequence of): b. Essential Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 6 years 25 years			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Harjit Singh				29c. License number D0014160		29d. Date signed (Month, Day, Year) 11/30/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225											
31. Date filed (Month, Day, Year) DEC 5 2000				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38424

AMENDED# 23&amp;27 per ME G793 031401 SS

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EBONY SHY'TERRA PERKINS

2. Date of Death

Month Day Year  
NOVEMBER 27, 2000

3. Time of Death

01:33 AM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

218-53-7204

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

1 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-4-98

9. Birthplace (State or Foreign Country)

BALTO MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTO.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

218 S-CAROL ST.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

Eddie Perkins

18. Mother's Name (First, Middle, Maiden Surname)

NALISA PITHMAN

19a. Informant's Name/Relationship (Type, Print)

NALISA PITHMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 S-CAROL ST-BALTO MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

VOSHILL GARDENS

Date

12-5-00

20c. Location - City or Town, State

BALTO MD.

21. Signature of Funeral Service Licensee

Wesley Clark

22. Name and Address of Facility

CHARIS F.H.

2007 EASTERN AVE

BALTO MD 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE VIRAL SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. L. Locke, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOVEMBER 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. L. Locke, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

J. L. Locke

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38425

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carlotta Patricia Pursley

2. Date of Death  
Month Day Year  
December 1, 20003. Time of Death  
15:58 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

218-36-7202

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 3 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14306 Dairydale Rd.

10f. Zip Code

21013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

18e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)Travel Agency Administration  
Coordinator

16b. Kind of Business/Industry

Travel

17. Father's Name (First, Middle, Last)

Elwood Levin Tabor

18. Mother's Name (First, Middle, Maiden Surname)

Carlotta Ann Bennett

19a. Informant's Name/Relationship (Type, Print)

Michael Louis Pursley, Sr., husband

14306 Dairydale Rd., Baldwin, MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Memorial Gardens Timonium, MD 21093

Date  
12/5/00

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Massive intra-abdominal hemorrhage

Approximate  
Interval Between  
Onset and Death

Hours

Due to (or as a consequence of):

b. Disseminated intravascular coagulation

Hours  
to days

Due to (or as a consequence of):

c. Possible sepsis

Days

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard L. Siegel

29c. License number

D28885

29d. Date signed (Month, Day, Year)

12/02/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Howard L. Siegel, M.D.

Greater Baltimore Medical Center,  
6701 N. Charles Street, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

Bryan W. Clary

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Pursley, Carlotta

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38426

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Phillips				2. Date of Death Month 12 Day 1 Year 2000		3. Time of Death 8 10 a.m.		
	4a. Facility Name (If not institution, give street and number) 4710 Wakefield Road Apt 204				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-56-3044		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) 7 21-1950		
	9. Birthplace (State or Foreign Country) S.C.		10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4710 Wakefield Road Apt 204		10f. Zip Code 21216		10g. Citizen of What Country? U S A	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 2 years		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sorter		16b. Kind of Business/Industry Maryland Hospital Laundry					
17. Father's Name (First, Middle, Last) Henry Fullard				18. Mother's Name (First, Middle, Maiden Surname) Julia Phillips					
19a. Informant's Name/Relationship (Type, Print) Nichole Dawson-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Kending Drive Owings Mills, Md 21117					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 12-6-00		20c. Location - City or Town, State Randallstown, Md			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiorespiratory arrest</i> Due to (or as a consequence of): b. <i>Probable Cardiac arrhythmia</i> Due to (or as a consequence of): c. <i>HASCD</i> Due to (or as a consequence of): <i>MARKED Exogenous obesity</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus type 2</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D18350		29d. Date signed (Month/Day, Year) 12/04/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA JENKINS, MD 2300 GARRISON BLVD Suite 2216		31. Date filed (Month, Day, Year) DEC 5 2000		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38427

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven R. Pace				2. Date of Death Month 11 Day 30 Year 2000				3. Time of Death 6 00 p.m.	
	4a. Facility Name (If not institution, give street and number) 13 Dell Court				4b. City, Town, or Location of Death Woodlawn				4c. County of Death Balto	
Funeral Director	5. Social Security Number 217-20-0904		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) 1-2-1927		9. Birthplace (State or Foreign Country) Va	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md		10b. County Balto		10c. City, Town or Location Woodlawn				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 13 Dell Court				10f. Zip Code 21244		10g. Citizen of What Country? U S A			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed			16b. Kind of Business/Industry Upholsterer Company		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Roosevelt Pace				18. Mother's Name (First, Middle, Maiden Surname) Willie Jones					
	19a. Informant's Name/Relationship (Type, Print) Pearl Pace-Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3924 Oakford Avenue Baltimore, Md 21215					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park		20c. Location - City or Town, State 12/5/00 Arbutus, Md					
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Non Hodgkins Lymphoma Due to (or as a consequence of):								Approximate Interval Between Onset and Death 15 months	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D46118		29d. Date signed (Month, Day, Year) Dec 4, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET COOPER MD 1447 York Rd Lutherville MD 21093									
	31. Date filed (Month, Day, Year) DEC 5 2000				32. Registrar's Signature <i>[Signature]</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38428

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vishakha Upendra Patel				2. Date of Death Month Day Year December 2, 2000				3. Time of Death 10:00AM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-13-3270		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) JULY 26, 1945		9. Birthplace (State or Foreign Country) India	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Arbutus	
To Be Completed by Funeral Director	10e. Street and Number 5601 Kallen Court				10f. Zip Code 21227		10g. Citizen of What Country? India			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian Indian			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Ranchhodbhai Patel				18. Mother's Name (First, Middle, Maiden Surname) Kamlaben B. Patel					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Upendra G. Patel/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Kallen Court Arbutus, MD 21227					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 12-3-00		20c. Location - City or Town, State Baltimore, MD			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Massive stroke Due to (or as a consequence of): b. Subdural hematoma Due to (or as a consequence of): c. Anoxic brain injury Due to (or as a consequence of): d. Respiratory Failure								Approximate Interval Between Onset and Death 14 days 21 days 14 days 21 days	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disaster mellitus Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Phil Buescher MD Union Memorial Hospital		29c. License number MD J845		29d. Date signed (Month, Day, Year) December 2, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phil Buescher MD Union Memorial Hospital				31. Date filed (Month, Day, Year) DEC 5 2000		32. Registrar's Signature Beverly B. Sparks			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38429

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert George Peterson				2. Date of Death Month Day Year Dec. 2, 2000		3. Time of Death 6:30AM	
	4a. Facility Name (If not institution, give street and number) John Hopkins Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-26-9996		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 18, 1927	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1902 Cedar Road		10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Peterson Lumber Co. Inc.			
	17. Father's Name (First, Middle, Last) Robert A. Peterson				18. Mother's Name (First, Middle, Maiden Surname) Christine M. Schneder			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Loreen Peterson- Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Cedar Road Pasadena, Maryland 21122			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Cemetery		20c. Location - City or Town, State 12/7/00 Marriotsville, MD			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Heather Cain				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. CORONARY ARTEROSCLEROSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Francis X. Strain, M.D.		29c. License number D44715		29d. Date signed (Month, Day, Year) 12.4.00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS X. STRAIN, M.D.				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL #907 BALT MD			
	31. Date filed (Month, Day, Year) DEC 5 2000		32. Registrar's Signature B. Sparks		21212			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

200 NOV 55 11:57

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38430

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED LAWANA RIPLEY

2. Date of Death

DEC. 1, 2000

3. Time of Death

6:50 P.M.

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE-- CROMWELL

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

235-40-9513

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

5/13/25

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6808 COLLINSDALE ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH GRADE

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

IRS

17. Father's Name (First, Middle, Last)

ORVILLE RIPLEY

18. Mother's Name (First, Middle, Maiden Surname)

LELA BOYD

19a. Informant's Name/Relationship (Type, Print)

O. WOODROW DILS COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12300 ROSSLARE RIDGE RD. #107 Timonium, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

12/4/00

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Arteriosclerotic coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

M. Kowalowski M.D.

D21022

12-4-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M. Kowalowski 7672 BELAIR Rd BALTO MD. 21236

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38431

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice M. Russell

2. Date of Death

11 29 2000

3. Time of Death

12:35 pm

4a. Facility Name (If not Institution, give street and number)

Broadmead

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-74-7828

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/22/1907

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

13801 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home Keeping

17. Father's Name (First, Middle, Last)

Edward H. Hess

18. Mother's Name (First, Middle, Maiden Surname)

Alice Humphreys

19a. Informant's Name/Relationship (Type, Print)

Mrs. Diana Russell Deacon/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 MacArthur Lane Stamford, CT 06902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery

Date

12/2/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home  
7401 Belair Rd. Baltimore, Maryland 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CVA new

Due to (or as a consequence of):

b.

ASCVD

Due to (or as a consequence of):

c.

multi infarct dementia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

11/27/00

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

29a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D22627

29d. Date signed (Month, Day, Year)

11/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F. SANZARO MD, 13801 YORK RD, COCKEYSVILLE MD 21030

State  
Registrar

31. Date filed (Month, Day, Year)

DEC - 5 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38432

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Temple Arnett Ray

2. Date of Death

Month Day Year  
November 27, 2000

3. Time of Death

8:30 pm

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

219-78-8117

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
3-5-1946

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2000 Madison

10f. Zip Code

21217

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
8th grade N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Doss Arnett, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Mary Morris

19a. Informant's Name/Relationship (Type, Print)

Wilbert J. Ray, Sr- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2000 Madison Avenue Apt 1A Baltimore, Md 21217

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park

Date

12-1-00

20c. Location - City or Town, State

Woodlawn, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. End Stage Renal Disease

Due to (or as a consequence of):

c. Respiratory Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

K. Butt

29c. License number

P 14572

29d. Date signed (Month, Day, Year)

11/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Butt, M.D. 40 Maryland General Hospital

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38433

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD S. ROWE

2. Date of Death

Month Day Year  
NOV. 30 2000

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

OAK CREST VILLAGE CARE CENTER

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-07-9427

6. Sex

X ☒ M ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 20, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

211 Wampler Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last)

Martin Luther Rowe

18. Mother's Name (First, Middle, Maiden Surname)

Irene Stonebraker

19a. Informant's Name/Relationship (Type, Print)

Betty I. King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11411 Marvon Rd. Kingsville, Md. 21087

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12-1-2000

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home

7401 Belair Rd. Baltimore, Md.

23a. Print, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTINFARCT DEMENTIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES / HYPERTENSION / CORONARY

ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide ☐ Could not be determined  
☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kendall R. Faules

29c. License number

D05643

29d. Date signed (Month, Day, Year)

11/30/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Faulner / 8800 Walther Blvd / Baltimore MD 21234

State  
Registrar

31. Date filed (Month, Day, Year)

DEC - 5 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Page 1

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

PHYSICAL CHEMISTRY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#12 PER F.H. G790 12-12-2000 JAB

## Certificate of Death

Reg. No.

00 38434

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN RIGNEY</b>		2. Date of Death Month <b>NOVEMBER</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>8:35PM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>230-32-7390</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>AUG. 14, 1928</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MARYLAND</b>	10b. County <b>ANNE ARUNDEL</b>	10c. City, Town or Location <b>BROOKLYN PARK</b>		10d. Inside City Limits <b>1 Yes 2 No</b>
	10e. Street and Number <b>417 BON AIR ROAD</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>
	14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8 College (14 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BUS DRIVER</b>
	16b. Kind of Business/Industry <b>TRANSPORTATION</b>		17. Father's Name (First, Middle, Last) <b>DAN RIGNEY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ELLA OAKES</b>
	19a. Informant's Name/Relationship (Type, Print) <b>CONSTANCE RIGNEY (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>417 BON AIR ROAD, BROOKLYN PARK, MD. 21225</b>		
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		20c. Location - City or Town, State <b>BROOKLYN PARK, MD.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
	a. <b>ADULT RESPIRATORY DISTRESS SYNDROME TWO DAYS</b>				
	Due to (or as a consequence of):				
	b. <b>ASPIRATION PNEUMONIA</b>				<b>ONE WEEK</b>
	Due to (or as a consequence of):				
	c. <b>LUNG CARCINOMA</b>				<b>ONE MONTH</b>
	Due to (or as a consequence of):				
	d.				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	<b>CEREBROVASCULAR ACCIDENT</b>				
<b>MYOCARDIAL INFARCTION</b>					
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>					
24a. Was an autopsy performed? <b>1 Yes 2 No</b>					
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>					
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>					
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <b>1 Yes 2 No</b>					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>					
29b. Signature and title of certifier 					
29c. License number <b>P-14121</b>					
29d. Date signed (Month, Day, Year) <b>NOVEMBER 30 2000</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SUMET SAWHNEY HARBOR HOSPITAL CENTER, BALTIMORE</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38435

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lottie Jane Rider</b>				2. Date of Death Month <b>Nov.</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>9:20 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>6910 Edwards Ave</b>				4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>225-24-0582</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jun 13, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Va.</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>6910 Edwards Ave</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Thomas J. Davis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Artrip</b>		19a. Informant's Name/Relationship (Type, Print) <b>Ebert Rider</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6910 Edwards Ave. Dundalk, Md. 21222</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Cem.</b>		Date <b>Dec 4 2000</b>		20c. Location - City or Town, State <b>Timonium, Md.</b>		
21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222</b>						
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Carcinoma of Breast 1 year</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitel: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Evangelos C. Lignos MD</b>						
		29c. License number <b>D19589</b>		29d. Date signed (Month, Day, Year) <b>12-1-00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EVANGELOS C. LIGNOS 7801 YORK Rd Towson MD 21204</b>								
31. Date filed (Month, Day, Year) <b>DEC 4 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL



00-6839-005  
00-334

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38435

amend item 23a, 27, 28a, b, c, d, e, f per me G790 12/21/00 yf

JASON THOMAS RUBY

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jason Thomas Ruby</b>						2. Date of Death Month Day Year <b>NOVEMBER 30, 2000</b>		3. Time of Death <b>6:45 P.M.</b>		
	4a. Facility Name (If not Institution, give street and number) <b>HAWK'S COVE ON HART MILLER ISLAND</b>						4b. City, Town, or Location of Death <b>NORTH POINT</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>220-11-7398</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>20</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 6, 1980</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		
	Usual Residence of Decedent										
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>507 Kosoak Rd.</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 YRS</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>			16b. Kind of Business/Industry <b>Tavern</b>				
17. Father's Name (First, Middle, Last) <b>Jack Ruby</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Denise Gunter</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Denise Ruby mother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>507 Kosoak Rd. Essex Md. 21220</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		Date <b>Dec. 5, 2000</b>		20c. Location - City or Town, State <b>Baltimore</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <b>DROWNING ASSOCIATED WITH ACUTE ETHANOL</b> a. <b>INTOXICATION</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> O/A Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found: 11/30/00</b>		28b. Time of Injury <b>found: 12:10</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject found in water</b>			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found at Hawk's Cove</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Hart Miller Island Baltimore Co., Md</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>DECEMBER 1, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J. Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>DEC - 5 2000</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38437

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE RICHARDSON</b>		2. Date of Death Month <b>December</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>1347</b>					
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>					
Funeral Director	5. Social Security Number <b>217-18-9186</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.					
	Usual Residence of Decedent 10a. State <b>MARYLAND</b> 10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number <b>1400 MADISON ST. apt. 715</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yaa or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:					
	14. Race - American Indian, Black, White, etc. <b>AFRO-AMERICAN</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (1-4 or 5+)							
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>BRADS OF PIKESVILLE</b>							
	17. Father's Name (First, Middle, Last) <b>JOHN HENRY LAKE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH JOHNSON</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>YVONNE R. GUARTE (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1027 CATHEDRAL ST. APT 7C BALTO, MD. 21201</b>							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		20c. Location - City or Town, State <b>DEC. 8, 2000 BALTO, MD.</b>					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>HYPERTENSION</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>Years</b>  <b>one hour</b></td> </tr> <tr> <td>b. <b>ARRHYTHMIA</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)	a. <b>HYPERTENSION</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>Years</b>  <b>one hour</b>	b. <b>ARRHYTHMIA</b> Due to (or as a consequence of):	c. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <b>HYPERTENSION</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>Years</b>  <b>one hour</b>								
	b. <b>ARRHYTHMIA</b> Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of certifier  29c. License number <b>RES 000</b> 29d. Date signed (Month, Day, Year) <b>DECEMBER 3, 2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HORACE K. LIANG, MD 600 N. WOLFE STREET BALTIMORE MD 21287</b>										
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b> 32. Registrar's Signature										





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38438

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eura Lee Smith</b>				2. Date of Death Month Day Year <b>December 1 2000</b>				3. Time of Death <b>4:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>215-14-0318</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>8/13/1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>1630 Williams Avenue</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>	
16b. Kind of Business/Industry <b>Balto. Co. Public Sch</b>		17. Father's Name (First, Middle, Last) <b>John Kosko</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jenny Failey</b>		19a. Informant's Name/Relationship (Type, Print) <b>Jay Brady (son)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2307 Riverside Drive, Baltimore, Maryland 21221</b>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Mem. Park</b>		20c. Location - City or Town, State <b>12/4/2000 Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adult Respiratory Distress Syndrome</b> Due to (or as a consequence of): <b>b. Coumadin Skin Necrosis</b> Due to (or as a consequence of): <b>c. Clostridium Difficile Colitis</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0055331</b>	
29d. Date signed (Month, Day, Year) <b>12/1/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Warren MD 9000 Franklin Square Drive Baltimore Maryland 21237</b>		31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Smith, Eura  
Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38439

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Cecelia Seato				2. Date of Death Month Day Year December 2 2000				3. Time of Death 5:28 AM					
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 217-18-9127		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Dec. 29, 1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Rosedale				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
10e. Street and Number 1911 Ellinwood Road				10f. Zip Code 21237				10g. Citizen of What Country? U.S.A.						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home						
17. Father's Name (First, Middle, Last) Unknown Esler						18. Mother's Name (First, Middle, Maiden Surname) Julia Krusewski								
19a. Informant's Name/Relationship (Type, Print) Casimir John Seato (husband)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Ellinwood Road, Baltimore, Maryland 21237								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Mary Cem.		Date 12/6/2000		20c. Location - City or Town, State Baltimore, Maryland						
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Bacteremia Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week 1 week														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. myocardial infarction Coronary artery														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier S. Repuraj MD				29c. License number D 53720				29d. Date signed (Month, Day, Year) 12/02/2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Repuraj MD, 2112 Belair Rd #9, Fallston, MD 21047														
31. Date filed (Month, Day, Year) DEC 05 2000				32. Registrar's Signature 										

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38440

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paula Smallwood</b>				2. Date of Death Month <b>Nov</b> Day <b>29</b> Year <b>2000</b>				3. Time of Death <b>11:15 pm</b>					
	4a. Facility Name (If not institution, give street and number) <b>Bon Secour Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>					
Funeral Director	5. Social Security Number <b>218-46-4774</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Age (In yrs. last birthday) <b>51</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>July 29, 1949 Maryland</b>			
	9. Birthplace (State or Foreign)													
To Be Completed by Funeral Director	10a. State <b>MD</b>				10b. County <b>Baltimore</b>				10c. City, Town or Location <b>Woodlawn</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>7011 Rudisill Ct. Apt. 1-B</b>				10f. Zip Code <b>21244</b>				10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1yr.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>				16b. Kind of Business/Industry <b>State of MD.</b>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Henry Logan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Watkins</b>									
	19a. Informant's Name/Relationship (Type, Print) <b>Monique N. Smallwood - daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 Yardley Ct. Woodlawn, MD 21244</b>									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>				20c. Location - City or Town, State <b>12-5-00 Arbutus, MD.</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary P. March Funeral Home P.A. 8740 Fredhillon Pass Balto, MD. 21229</b>									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>cardiac arrhythmia: ventricular fibrillation</b> Due to (or as a consequence of): b. <b>acute frontal cerebrovascular accident</b> Due to (or as a consequence of): c. <b>Septicemia</b> Due to (or as a consequence of): d. <b>Endstage renal disease 2° to diabetes mellitus</b>													
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>acess failure</b> <b>Pneumonia</b>													
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
State Registrar	29b. Signature and title of certifier  <b>Mages Gebremariam MD</b>				29c. License number <b>D18327</b>				29d. Date signed (Month, Day, Year) <b>11/30/2000</b>					
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Moges Gebremariam MD. 4660 Wilkens Ave Balto 21229</b>													
State Registrar	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature  <b>B. Sparks</b>									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38441

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred McCloy Shaner</b>				2. Date of Death Month Day Year <b>November 29, 2000</b>				3. Time of Death <b>5:10PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>				4c. County of Death <b>Prince George's</b>			
Funeral Director	5. Social Security Number <b>220-44-3445</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 21 1903</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number <b>4102 Kenny Street</b>				10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auditor</b>			16b. Kind of Business/Industry <b>US Government</b>				
	17. Father's Name (First, Middle, Last) <b>Oliver Egy McCloy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margie Alvertia Smith</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Laurie Gebauer Deane/ Gr. Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4102 Kenny Street, Beltsville, MD 20705</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. Location - City or Town, State <b>12/4/00 Brentwood, MD</b>					
	21. Signature of Funeral Service Licensee  <b>MCO770</b>				22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Aspiration Pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>1 Day</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hiatal Hernia</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28e. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
State Registrar	29b. Signature and Title of certifier  <b>MD</b>				29c. License number <b>D54488</b>		29d. Date signed (Month, Day, Year) <b>November 30, 2000</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bennett So, MD 8317 Cherry Lane, Laurel, MD 20707</b>											
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2000 NOV 35 PM 1:59

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38442

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edgar Wilson Swank

2. Date of Death

Month Day Year  
December 1, 2000

3. Time of Death

1:10AM

4a. Facility Name (If not institution, give street and number)

6304 Brooklyn Bridge Road

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

190-18-0217

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 18, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6304 Brooklyn Bridge Road

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Planning Officer

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Samuel Swank

18. Mother's Name (First, Middle, Maiden Summa)

Mary Clarissa Tharpe

19a. Informant's Name/Relationship (Type, Print)

Virginia Swank/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6304 Brooklyn Bridge Road, Laurel, MD 20707

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Northumberland Memorial Pk 2000

Data

Dec. 6,

20c. Location - City or Town, State

Sunbury, PA

21. Signature of Funeral Service Licensee

G. S. K.

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Alzheimer's Disease

e. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lynne A. Gaynes, M.D.

29c. License number

D25775

29d. Date signed (Month, Day, Year)

December 1, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lynne A. Gaynes, M.D. 14201 Laurel Park Drive #214, Laurel, MD 20707

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

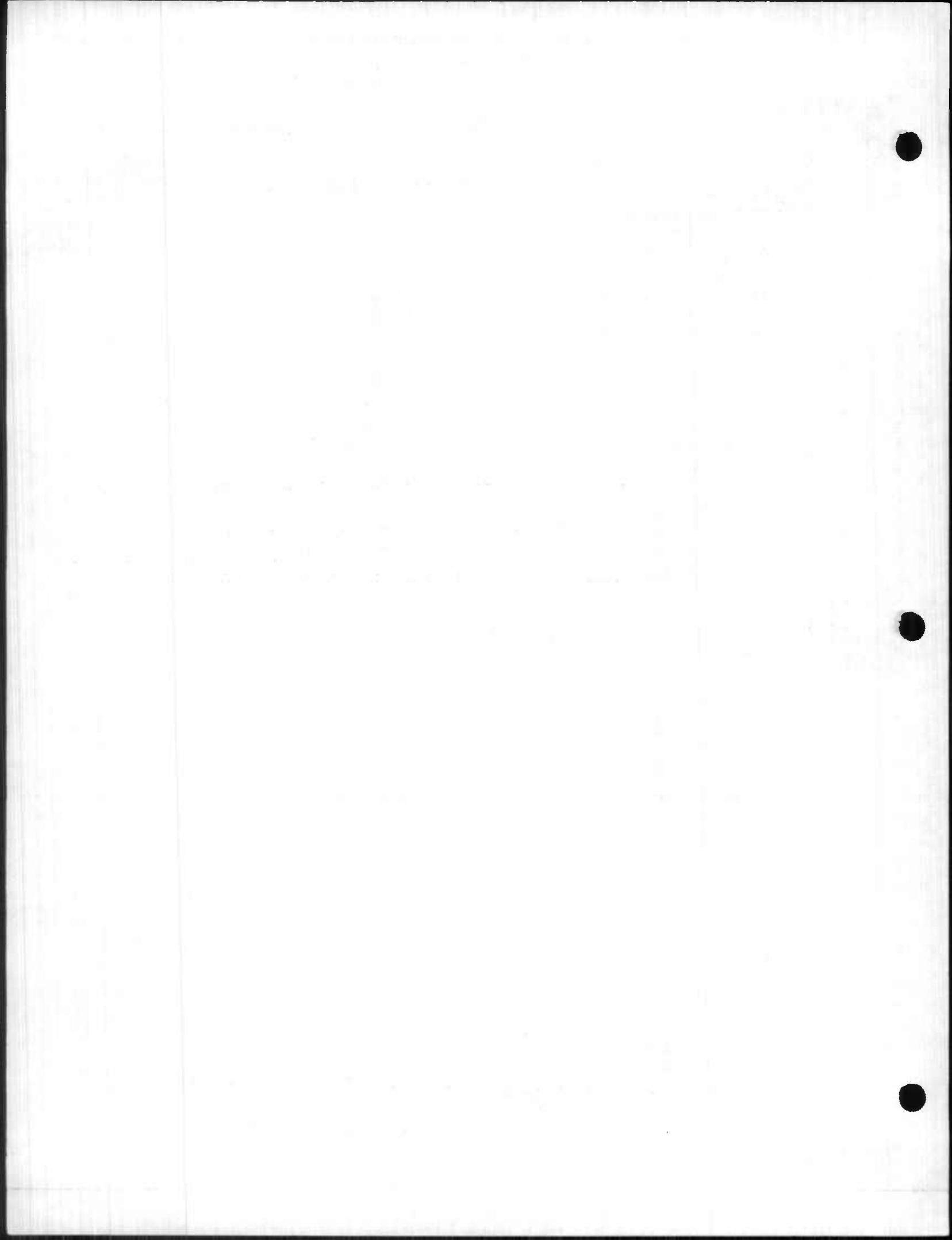
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38443

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian K. Smith</b>				2. Date of Death Month <b>November</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>6:20 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>219-12-2625</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 7, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Utah</b>		10a. State <b>MD</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>5614 Jamestown Road</b>		10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SchoolBus Driver</b>		16b. Kind of Business/Industry <b>Prince George Co. Board of Education</b>		17. Father's Name (First, Middle, Last) <b>Thomas Krisman</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Antonette Andler</b>		19a. Informant's Name/Relationship (Type, Print) <b>Eva Reeley/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5614 Jamestown Road, Hyattsville, MD 20782</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Emmanuel UM Church Cem.</b>		20c. Location - City or Town, State <b>Scaggsville, MD</b>		21. Signature of Funeral Service Licensee <b>Gus K.</b>		22. Name and Address of Facility <b>Donaldson Funeral Home, P.A.</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <b>ischemic cardiomyopathy</b> Due to (or as a consequence of): b. <b>coronary artery disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval between Onset and Death <b>1/15</b> <b>1/15</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11-30-2000</b>		
28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Nader G. G. G.</b>		29c. License number <b>D41978</b>		29d. Date signed (Month, Day, Year) <b>11-30-2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nader G. G. G. 9801 Greenbelt Rd Lantham M.D.</b>		31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Name <b>20706</b>		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38444

amend item 19a per fh G790 12/5/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE ELIZABETH SAHLMAN</b>				2. Date of Death Month Day Year <b>DEC. 4, 2000</b>		3. Time of Death <b>5:00 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>715 SEQUOIA DRIVE</b>				4b. City, Town, or Location of Death <b>EDGEWOOD</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>212-07-0558</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10/22/11</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>EDGEWOOD</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>715 SEQUOIA DRIVE</b>		10f. Zip Code <b>21040</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNDERWRITER</b>				16b. Kind of Business/Industry <b>INSURANCE CO.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>AUGUST F.C. DAMM</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CAROLINA KRICH</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN D. LOCKERMAN - DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 SEQUOIA DRIVE EDGEWOOD, MD 21040</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH CEM.</b>		20c. Location - City or Town, State <b>12/7/00 PARKVILLE, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>			
Physician /Medical Examiner	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. <b>CHRONIC OBSTRUCTIVE PULMONARY Ds.</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- COPD</b> <b>- CHF</b> <b>- Atrial Fibrillation</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>12/4/00</b>			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier 				29c. License number <b>042600</b>			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>12/4/00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THOMAS BIONDO, MD 319 SOUTH UNION AVE. HAVRE de GRACE, MD 21078</b>			
	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38445

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Schaffer				2. Date of Death Month Day Year Nov 30 2000				3. Time of Death 6:25am		
	4a. Facility Name (If not institution, give street and number) SAINT AGNES HEALTHCARE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-24-9737		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) October 19, 1929 Maryland		
	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodlawn		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 2030 Featherbed Lane				10f. Zip Code 21207				10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk				16b. Kind of Business/Industry Stationary Business		
	17. Father's Name (First, Middle, Last) William Henry Schaffer				18. Mother's Name (First, Middle, Maiden Surname) Maude Virginia Worsdell						
	19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret Schaffer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2030 Featherbed Lane Woodlawn, MD 21207						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 12/2/00		20c. Location - City or Town, State Woodlawn, Maryland		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 3 DAYS						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE. CEREBROVASCULAR DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier M.D.				29c. License number P 14446		29d. Date signed (Month, Day, Year) Nov 30 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARL QUIST - PERSON M.D. ST AGNES HEALTHCARE, BALTIMORE				31. Date filed (Month, Day, Year) DEC 05 2000				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38446

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Laura Lucinda Schulze

2. Date of Death

December 2 2000

3. Time of Death

9:31pm

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-05-1275

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1917

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker - Artist

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lawrence M. Dennis

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Hale

19a. Informant's Name/Relationship (Type, Print)

Richard Burt Schulze/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8820 Walther Blvd., Parkville, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

12/5/00

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma

Due to (or as a consequence of):

b. Fall

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Cerebrovascular Accident, Hypertension

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

12/2/2000

28b. Time of Injury

2:45AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8800 Walther Blvd Balto, MD

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

D37612

29d. Date signed (Month, Day, Year)

December 3-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mohamad Alabrash MD 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

[Signature]

State  
Registrar

To Be Completed by Funeral Director

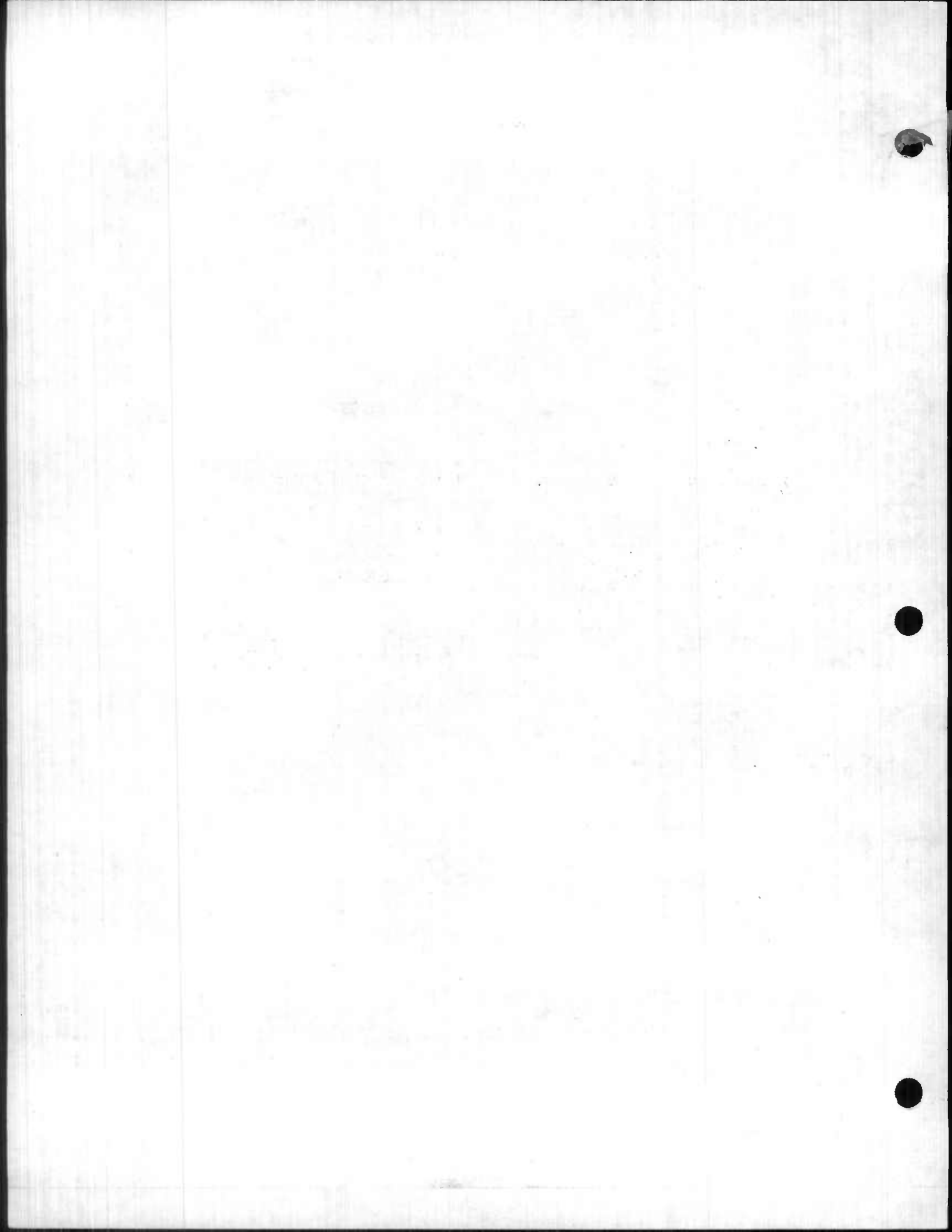
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Schulze, Dorothy  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38447

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy May Scheve

2. Date of Death

Month Day Year  
December 3 2000

3. Time of Death

11:10 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

213-20-7897

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 7, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 Ridge Avenue

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Hospital/Nursing Home

17. Father's Name (First, Middle, Last)

John Williams

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Terry

19a. Informant's Name/Relationship (Type, Print)

Charles Joseph Scheve/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 Ridge Avenue Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/4/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. PARKINSON'S DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

12.4.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

31. Date filed (Month, Day, Year)

DEC 5 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SCHEVE, DOROTHY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38448

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

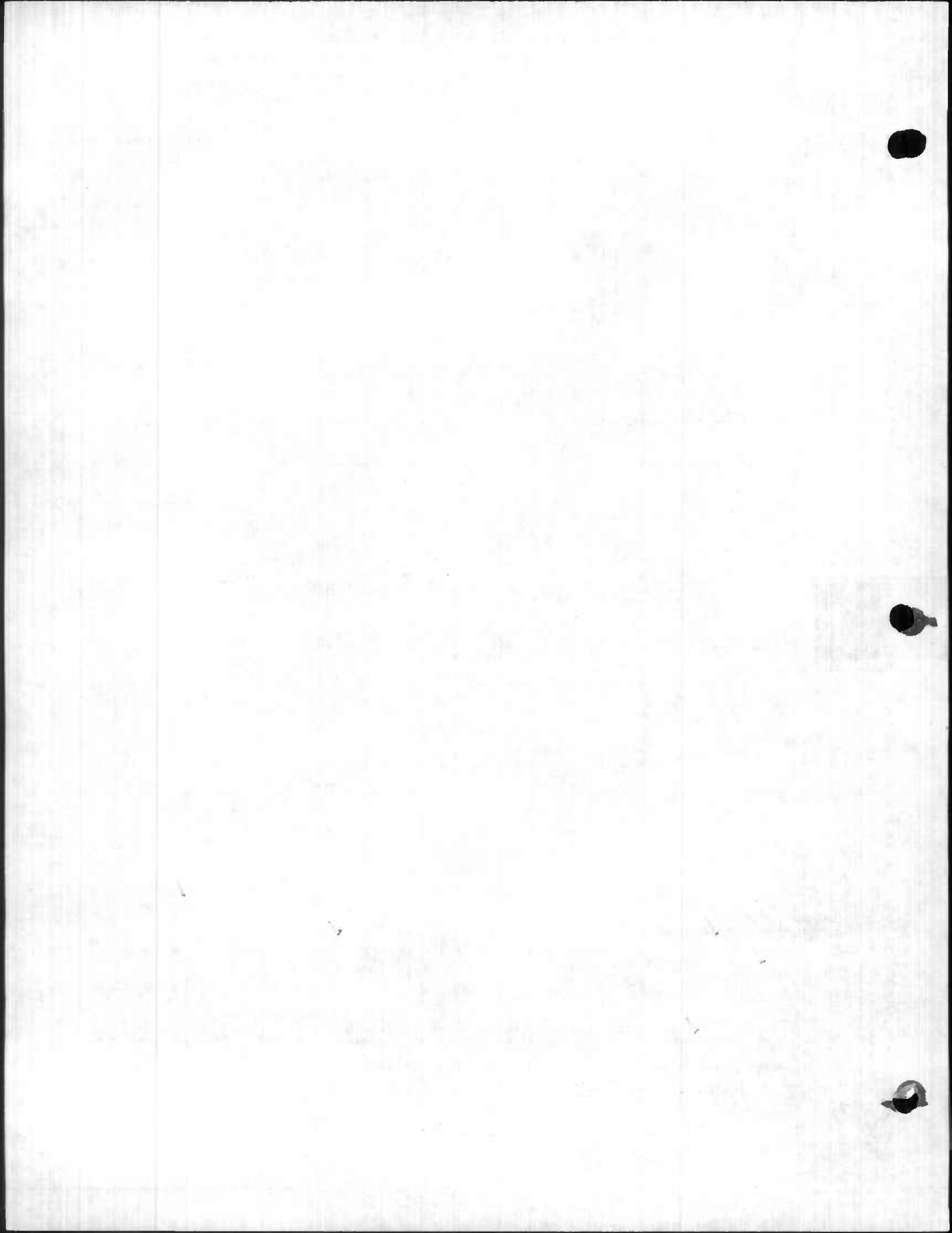
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>James Douglas Scott</b>				2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>10:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Catonsville Commons</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>478-32-1617</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 25, 1934</b>	
9. Birthplace (State or Foreign Country) <b>Iowa</b>		10. Usual Residence of Decedent		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Millersville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8256 Ahearn Road</b>				10f. Zip Code <b>21108</b>		10g. Citizen of What Country? <b>USA</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Electronics</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
17. Father's Name (First, Middle, Last) <b>Fred Cleo Scott</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Velma Gregson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Eric James Scott / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1612 T Street N.W. Washington D.C. 20009</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>12-1-00 Baltimore, MD.</b>		21. Signature of Funeral Service Licensee <b>Thomas Gregor</b>	
22. Name and Address of Facility <b>Cremation Society Of MD, Inc.</b>		22. Name and Address of Facility <b>299 Frederick Road Baltimore, MD. 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Cirrhosis of Liver</b> Due to (or as a consequence of): b. <b>Carcinoma of Common Bile Duct</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>yr</b> <b>yr.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier <b>Bukhina</b>		29c. License number <b>D36942</b>		29d. Date signed (Month, Day, Year) <b>November 30, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. JURAKHIA, MD 1009, Frederick Rd. Catonsville, MD 21228</b>	
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>		32. Registrar's Signature <b>B. Spahr</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38449

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) <i>William H. Sills JR</i>		2. Date of Death Month: <i>December</i> Day: <i>02</i> Year: <i>2000</i>		3. Time of Death <i>02:40 P.M.</i>	
4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
5. Social Security Number <i>218-46-9516</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.	
8. Date of Birth Month: <i>12</i> Day: <i>1</i> Year: <i>1948</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>			
10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>151 North Linwood Ave.</i>		10f. Zip Code <i>21224</i>	
10g. Citizen of What Country? <i>USA</i>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <i>11th</i> College (1-4 or 5+):	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Warehouse man</i>		16b. Kind of Business/Industry <i>E &amp; H Furniture</i>		17. Father's Name (First, Middle, Last) <i>William H Sills SR.</i>	
18. Mother's Name (First, Middle, Maiden Surname) <i>Aleatha Handy</i>		19a. Informant's Name/Relationship (Type, Print) <i>Shirley Parker - sister</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>151 N. Linwood Ave. 21224 Baltimore, MD</i>	
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Vashell Cemetery</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
20d. Date <i>12/11/00</i>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Spencer's Memorial Chapel P.C. Baltimore, MD 21213</i>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <i>PARTIAL</i> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <i>[Signature]</i>	
29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>December 3, 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</i>	
31. Date filed (Month, Day, Year) <i>DEC 05 2000</i>		32. Registrar's Signature <i>[Signature]</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38450

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Veronica E. Stafford				2. Date of Death Month Day Year Nov. 16 2000				3. Time of Death 17:18			
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A			
Funeral Director	5. Social Security Number 217-38-3642		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) September 24, 1942		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Washington		10c. City, Town or Location Hancock				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 49 Vista Village				10f. Zip Code 21750				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Operator				16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Thomas White				18. Mother's Name (First, Middle, Maiden Surname) Ruth Patterson							
	19a. Informant's Name/Relationship (Type, Print) Lewis R. Stafford/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Vista Village Hancock, MD 21750							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans		Date 11/21/2000		20c. Location - City or Town, State Cumberland, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Coronary Artery Disease Due to (or as a consequence of): b. Diabetes Due to (or as a consequence of): c. End Stage Renal Disease Due to (or as a consequence of): d. Hypertension										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic peripheral vascular disease congestive heart failure status post sternectomy from coronary artery bypass grafting												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Robert A. Joy				29c. License number P14712		29d. Date signed (Month, Day, Year) Nov. 22, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A Joy MD 22 South Greene Street, Baltimore, Md 21201											
	31. Date filed (Month, Day, Year) DEC - 5 2000				32. Registrar's Signature 							
	State Registrar											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38451

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cecelia Louise Stokes</b>				2. Date of Death Month <b>November</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>6:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Richey Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-40-2137</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58</b> Yrs.		8. Date of Birth Month <b>Nov.</b> Day <b>4</b> Year <b>1942</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4934 Westhills Rd.</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Customer Service Representative</b>		16b. Kind of Business/Industry <b>Eastman Kodak</b>		17. Father's Name (First, Middle, Last) <b>Maxwell Anderson Sr.</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Sykes</b>		19a. Informant's Name/Relationship (Type, Print) (Son) <b>Mr. Bernard A. Stokes</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>608 Charraway Rd. Balto. Md. 21229</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Diffuse large cell Lymphoma</b> Due to (or as a consequence of): <b>b. Chronic lymphocytic leukemia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>4mo</b> <b>10yo</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Iredell W. Iglerhart MD</b>	
	29c. License number <b>D33400</b>		29d. Date signed (Month, Day, Year) <b>11/29/2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Iredell W. Iglerhart III MD 500 W. University Pkwy Baltimore, MD 21210</b>		31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>	
State Registrar	32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Signature <b>[Signature]</b>		34. Registrar's Signature <b>[Signature]</b>		35. Registrar's Signature <b>[Signature]</b>	

ORIGINAL

Handwritten text at the top of the page, possibly a header or title.

Handwritten text in the upper middle section of the page.

Handwritten text in the middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38452

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence O. Tankersley</b>				2. Date of Death Month Day Year <b>Dec. 3, 2000</b>				3. Time of Death <b>1 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3838 Roland Avenue Apt. 804</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-05-0305</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 22, 1910</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, MD</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3838 Roland Avenue Apt. 804</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Purchasing Agent</b>		16b. Kind of Business/Industry <b>Seton Institute</b>				
17. Father's Name (First, Middle, Last) <b>Clarence Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Doris Warehime Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Southerly Ct. Unit 105 Towson, MD 21286</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Pk</b>		20c. Date <b>12/6/00</b>		20d. Location - City or Town, State <b>Parkville, MD</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Cerebrovascular Accident</b>										
23b. Approximate Interval Between Onset and Death <b>1 MIN</b>										
23c. Immediate Cause (Final disease or condition resulting in death) <b>ASCVD</b>										
23d. Due to (or as a consequence of): <b>20 yrs</b>										
23e. Due to (or as a consequence of):										
23f. Due to (or as a consequence of):										
23g. Due to (or as a consequence of):										
23h. Due to (or as a consequence of):										
23i. Due to (or as a consequence of):										
23j. Due to (or as a consequence of):										
23k. Due to (or as a consequence of):										
23l. Due to (or as a consequence of):										
23m. Due to (or as a consequence of):										
23n. Due to (or as a consequence of):										
23o. Due to (or as a consequence of):										
23p. Due to (or as a consequence of):										
23q. Due to (or as a consequence of):										
23r. Due to (or as a consequence of):										
23s. Due to (or as a consequence of):										
23t. Due to (or as a consequence of):										
23u. Due to (or as a consequence of):										
23v. Due to (or as a consequence of):										
23w. Due to (or as a consequence of):										
23x. Due to (or as a consequence of):										
23y. Due to (or as a consequence of):										
23z. Due to (or as a consequence of):										
23aa. Due to (or as a consequence of):										
23ab. Due to (or as a consequence of):										
23ac. Due to (or as a consequence of):										
23ad. Due to (or as a consequence of):										
23ae. Due to (or as a consequence of):										
23af. Due to (or as a consequence of):										
23ag. Due to (or as a consequence of):										
23ah. Due to (or as a consequence of):										
23ai. Due to (or as a consequence of):										
23aj. Due to (or as a consequence of):										
23ak. Due to (or as a consequence of):										
23al. Due to (or as a consequence of):										
23am. Due to (or as a consequence of):										
23an. Due to (or as a consequence of):										
23ao. Due to (or as a consequence of):										
23ap. Due to (or as a consequence of):										
23aq. Due to (or as a consequence of):										
23ar. Due to (or as a consequence of):										
23as. Due to (or as a consequence of):										
23at. Due to (or as a consequence of):										
23au. Due to (or as a consequence of):										
23av. Due to (or as a consequence of):										
23aw. Due to (or as a consequence of):										
23ax. Due to (or as a consequence of):										
23ay. Due to (or as a consequence of):										
23az. Due to (or as a consequence of):										
23ba. Due to (or as a consequence of):										
23bb. Due to (or as a consequence of):										
23bc. Due to (or as a consequence of):										
23bd. Due to (or as a consequence of):										
23be. Due to (or as a consequence of):										
23bf. Due to (or as a consequence of):										
23bg. Due to (or as a consequence of):										
23bh. Due to (or as a consequence of):										
23bi. Due to (or as a consequence of):										
23bj. Due to (or as a consequence of):										
23bk. Due to (or as a consequence of):										
23bl. Due to (or as a consequence of):										
23bm. Due to (or as a consequence of):										
23bn. Due to (or as a consequence of):										
23bo. Due to (or as a consequence of):										
23bp. Due to (or as a consequence of):										
23bq. Due to (or as a consequence of):										
23br. Due to (or as a consequence of):										
23bs. Due to (or as a consequence of):										
23bt. Due to (or as a consequence of):										
23bu. Due to (or as a consequence of):										
23bv. Due to (or as a consequence of):										
23bw. Due to (or as a consequence of):										
23bx. Due to (or as a consequence of):										
23by. Due to (or as a consequence of):										
23bz. Due to (or as a consequence of):										
23ca. Due to (or as a consequence of):										
23cb. Due to (or as a consequence of):										
23cc. Due to (or as a consequence of):										
23cd. Due to (or as a consequence of):										
23ce. Due to (or as a consequence of):										
23cf. Due to (or as a consequence of):										
23cg. Due to (or as a consequence of):										
23ch. Due to (or as a consequence of):										
23ci. Due to (or as a consequence of):										
23cj. Due to (or as a consequence of):										
23ck. Due to (or as a consequence of):										
23cl. Due to (or as a consequence of):										
23cm. Due to (or as a consequence of):										
23cn. Due to (or as a consequence of):										
23co. Due to (or as a consequence of):										
23cp. Due to (or as a consequence of):										
23cq. Due to (or as a consequence of):										
23cr. Due to (or as a consequence of):										
23cs. Due to (or as a consequence of):										
23ct. Due to (or as a consequence of):										
23cu. Due to (or as a consequence of):										
23cv. Due to (or as a consequence of):										
23cw. Due to (or as a consequence of):										
23cx. Due to (or as a consequence of):										
23cy. Due to (or as a consequence of):										
23cz. Due to (or as a consequence of):										
23da. Due to (or as a consequence of):										
23db. Due to (or as a consequence of):										
23dc. Due to (or as a consequence of):										
23dd. Due to (or as a consequence of):										
23de. Due to (or as a consequence of):										
23df. Due to (or as a consequence of):										
23df. Location (Street and Number or Rural Route Number, City or Town, State)										
23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury <b>M</b>										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>										
29c. License number <b>D25662</b>										
29d. Date signed (Month, Day, Year) <b>12/05/00</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gregory Walker 3333 N. Calvert Street Baltimore, MD 21218</b>										
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>										
32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38453

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Marie Taylor</b>				2. Date of Death Month Day Year <b>NOVEMBER 29 2000</b>		3. Time of Death <b>5:45am</b>	
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-22-0416</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 1, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Hydes</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>4701 Hydes Road</b>		10f. Zip Code <b>21082</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Child Care Worker</b>				16b. Kind of Business/Industry <b>Child Care</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>William Kozak</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Amy Etherton</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Jacquelyn Potter/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2308 Ellen Avenue, Baltimore, MD 21234</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore-Washington Crematory</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Bryan W. Clary</b>				22. Name and Address of Facility <b>Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b>						Approximate Interval Between Onset and Death <b>10 days</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and Title of Certifier <b>B. Eldadah MD Physician</b>				29c. License number <b>D0054303</b>		29d. Date signed (Month, Day, Year) <b>November 29, 2000</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Z.A. ELADDAH Greater Baltimore Medical Center 6701 N. Charles St. Baltimore, MD 21204</b>							
	31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>				32. Registrar's Signature <b>B. Eldadah</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38454

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jesse Carroll Tucker

2. Date of Death  
Month Day Year

Dec 1 2000 2010

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

215-12-3801

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

April 24 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel Co.

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

154 Carvel Beach Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintenance Foreman

16b. Kind of Business/Industry

Weyerhaeuser Company

17. Father's Name (First, Middle, Last)

Charles Dallas Tucker

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Emma Allen

19a. Informant's Name/Relationship (Type, Print)

Allen Z. Tucker (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1931 Wareham Road, Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/05/2000

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

John F. Allini

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.  
3204 Mountain Road, Pasadena, Md. 2112223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Cardiac Arrhythmia

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William R. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

12/1/00

30. Name and address of person who completed return of death (Item 23a) (Type, Print)

William R. Jones, MD

695 America 21035

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

Denise Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1900 was a year of great change for the world. The new century began with a sense of optimism and hope. The world was a different place than it had been in the previous century. The new century was a time of great change and progress. The world was a different place than it had been in the previous century. The new century was a time of great change and progress.

The world was a different place than it had been in the previous century. The new century was a time of great change and progress.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38455

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Cross Watson, Sr.					2. Date of Death Month Day Year December 1, 2000		3. Time of Death 9:35 AM			
	4a. Facility Name (If not institution, give street and number) Dulaney-Towson Heath Care Center					4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 219-16-3595		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 27, 1927		9. Birthplace (State or Foreign Country) Md.		
	Usual Residence of Decedent										
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Lutherville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 8209 White Manor Dr.					10f. Zip Code 21093		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner			16b. Kind of Business/Industry Watson's Garden Center			
17. Father's Name (First, Middle, Last) Maurice Michael Watson					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Cross						
19a. Informant's Name/Relationship (Type, Print) Mrs. Constance Watson/wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8209 White Manor Dr. Lutherville, Md. 21093						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial		Date 12/5/00		20c. Location - City or Town, State Timonium, Md.				
21. Signature of Funeral Service Licensee					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Sepsis</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 weeks 2 weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and Title of certifier <u>Attending Physician</u>					29c. License number D53642		29d. Date signed (Month, Day, Year) Dec 1 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X/AO 2 HCOU 3007 E Northern Parkway Baltimore 21216											
State Registrar		31. Date filed (Month, Day, Year) DEC 5 2000		32. Registrar's Signature <u>B. Sparks</u>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38456

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES WILLIAMSON</b>				2. Date of Death Month <b>Nov</b> Day <b>29th</b> Year <b>2000</b>		3. Time of Death <b>7:02 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MERCY HOSPITAL 301 ST PAUL PLACE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>915-52-1189</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 1, 1950 Maryland</b>	
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>200 N. Charles St.</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2 yrs.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>	
	17. Father's Name (First, Middle, Last) <b>William F. Williamson SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marion Adams</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ruthann W. Thomas-sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Summerwind Way Glen Burnie, MD 21061</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>126-00 Lansdowne, MD.</b>		20d. Date <b>2/22/99</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Serv. of March Funeral Home P.A. 870 Fredrickson Rd. Balt., MD 21229</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC ARITHMIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>DIABETES MELLITUS</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>P14692</b>		29d. Date signed (Month, Day, Year) <b>11/29/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GERARD J. F. HOGAN, MD MERCY HOSPITAL, 301 ST. PAUL PLACE BALTIMORE, MD</b>							
	31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38457

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roland LINWOOD White</b>			2. Date of Death Month <b>November</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>11:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>61 N. MONASTERY AVENUE</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-38-5679</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MARCH 14, 1942</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent						
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>61 N. MONASTERY AVENUE</b>			10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNEMPLOYED</b>			16b. Kind of Business/Industry <b>N/A</b>	
17. Father's Name (First, Middle, Last) <b>MICKEY WHITLOR</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MILDRED T. WHITE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>BETTIE FORD (FRIEND)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>61 N. MONASTERY AVE, BALTIMORE, MD 21229</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>12-2-00 CATONSVILLE, MARYLAND</b>		
21. Signature of Funeral Service Licensee <b>Roland N. White</b>			22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217</b>				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Sudden death</b> Due to (or as a consequence of): b. <b>Severe Hypertension</b> Due to (or as a consequence of): c. <b>Chronic obstructive lung disease</b> Due to (or as a consequence of): d. <b>Obesity</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Degenerative joint disease</b> <b>Depression</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Jayashree Ambale M.D.</b>			29c. License number <b>046596</b>		29d. Date signed (Month, Day, Year) <b>12/1/2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>1501 W Saratoga Street Baltimore M.D 21223</b>							
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>			32. Registrar's Signature <b>Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38458

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George J. Weaver, Sr.

2. Date of Death

November 29, 2000

3. Time of Death

11:30 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-22-2274

6. Sex

M 20 F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 2, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes 20 No

10e. Street and Number

1507 W. 36th Street

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Mill Worker

16b. Kind of Business/Industry

Steel Manufacturing

17. Father's Name (First, Middle, Last)

George W. Weaver, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Blessing

19a. Informant's Name/Relationship (Type, Print)

Patricia Saal

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8316 Nunley Drive Apt D Parkville, Maryland 21234

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory Baltimore-Washington

Date

12/4/00

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Lynn B. Henss

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211  
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic bronchitis

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

20 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Betsy A. Fay MD

29c. License number

D33220

29d. Date signed (Month, Day, Year)

12/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BETSY A. FAY MD 3730 FALLS ROAD BALTIMORE MD 21211

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 05 2000

32. Registrar's Signature

Betsy A. Fay

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38459

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Donald Lee White</i>				2. Date of Death Month <i>November</i> Day <i>28</i> Year <i>2000</i>		3. Time of Death <i>2:29 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>St. Agnes Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>none</i>	
Funeral Director	5. Social Security Number <i>219-40-8531</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>54</i> Yrs.		8. Date of Birth Month <i>March</i> Day <i>26</i> Year <i>1946</i>	
	9. Birthplace (State or Foreign Country) <i>North Carolina</i>		10a. State <i>Maryland</i>		10b. County <i>none</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>2002 Oakland ave.</i>		10f. Zip Code <i>21216</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>African American</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>none</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Taxi Driver</i>		16b. Kind of Business/Industry <i>Diamond Cab.</i>		17. Father's Name (First, Middle, Last) <i>Harry C. White</i>		
18. Mother's Name (First, Middle, Maiden Surname) <i>Rosa Bell Williams</i>		19a. Informant's Name/Relationship (Type, Print) <i>Phyllis Wooden - sister</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2816 Edman Ave. Baltimore, Maryland 21213</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion</i>		20c. Location - City or Town, State <i>Lansdowne, Maryland</i>		21. Signature of Funeral Service Licensee <i>Nancy M. Wallace</i>		22. Name and Address of Facility <i>Nancy M. Wallace Funeral Service 3405 W. Franklin St. Balto Md. 21229</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Charles Curtis MD</i>		
29c. License number <i>D0051865</i>		29d. Date signed (Month, Day, Year) <i>December 1, 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>CHARLES CURTIS MD ST AGNES HOSPITAL, BALTIMORE</i>		31. Date filed (Month, Day, Year) <i>DEC 5 2000</i>		
32. Registrar's Signature <i>[Signature]</i>		33. State Registrar <i>[Signature]</i>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.		

ORIGINAL



00-6775-510  
00-330

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38460

JOSH T. WATERMAN

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josh Thomas Waterman				2. Date of Death Month Day Year NOVEMBER 28, 2000		3. Time of Death 4:10P.M.	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 436-02-7211		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) APR 28, 1958	
	9. Birthplace (State or Foreign Country) New York		10a. State North Carolina		10b. County Wake		10c. City, Town or Location Raleigh	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 8808 Campfire Trail		10f. Zip Code 27615	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Furniture		17. Father's Name (First, Middle, Last) Roland M. Waterman	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Ruth Gabrielsen				19a. Informant's Name/Relationship (Type, Print) Roland M. Waterman/Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Widow Sweets Exeter, RI 02822	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 12-1-00 Baltimore, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Gunshot Wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 11/28/00			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury 1516Hr				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	28d. Describe how injury occurred Subject shot by police				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) highway			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State) at on 1/2 mile 56.1 Baltimore County				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier Theodore H. King				29c. License number O.C.M.E.			
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) NOVEMBER 29, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore H. King 111 Penn Street, Baltimore, Maryland 21201			
	31. Date filed (Month, Day, Year) DEC 5 2000				Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 38461

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHESTER WAGNER</b>		2. Date of Death Month <b>Dec (12)</b> Day <b>01</b> Year <b>2000</b>		3. Time of Death <b>02:47</b>
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>212-44-8029</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct.03 1944</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3530 Seventh Street</b>			10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Harbor Hospital</b>	
17. Father's Name (First, Middle, Last) <b>Jay Wagner</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Baier</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Alice Wagner (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3530 Seventh Street, Baltimore, Md. 21225</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>12/04/2000 Baltimore, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>McCully-Polyniak Funeral home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Unresponsive arrhythmia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>P1869</b>		29d. Date signed (Month, Day, Year) <b>December, 01, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHAI ROSEN, SURGICAL RESIDENT AT BAYVIEW MEDICAL CENTER</b>					
31. Date filed (Month, Day, Year) <b>DEC 05 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38462

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>JOSEPH WALTERS</u>		2. Date of Death Month <u>December</u> Day <u>2</u> Year <u>2000</u>		3. Time of Death <u>19:53</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>n/a</u>
Funeral Director	5. Social Security Number <u>219-28-6960</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>69</u> Yrs.	If Under 1 Year Months <u>0</u> Days <u>0</u>	If Under 24 Hrs. Hours <u>0</u> Min. <u>0</u>
	8. Date of Birth (Month, Day, Year) <u>April 07 1931</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
Usual Residence of Decedent					
10a. State <u>Md.</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>1437 Decatur Street</u>			10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>white</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Mechanic</u>		16b. Kind of Business/Industry <u>M.T.A.</u>	
17. Father's Name (First, Middle, Last) <u>Charles Walters</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Ola Minton</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Viola Walters (Wife)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1437 Decatur Street, Baltimore, Md. 21230</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		20c. Location - City or Town, State <u>12/06/2000 Baltimore, Md.</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>McCully-Polyniak Funeral Home P.A.</u> <u>130 E. Fort Ave. Baltimore, Md. 21230</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death <u>2 Days</u>					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>CORONARY ARTERY DISEASE, DIABETES MELLITUS, GALLBLADDER DISEASE</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>M</u>		28b. Time of Injury <u>1</u> Yes <u>2</u> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature] M.D.</u>		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>December 2, 2000</u>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>RICHARD EVERLEY WATERS 600 NORTH WOLFE STREET BALTIMORE MARYLAND 21287</u>					
31. Date filed (Month, Day, Year) <u>DEC 05 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



jhm

EDDIE

WILLIAM amend item 1,23a,27 per me G790 12/20/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38463

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Eddie William Jr.</u>		2. Date of Death Month <u>DECEMBER</u> Day <u>02</u> , Year <u>2000</u>		3. Time of Death <u>05:54 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>MERCY HOSPITAL</u>		4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>215-78-9090</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>40</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>4/5/1960</u>		9. Birthplace (State or Foreign Country) <u>South Carolina</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>927 N. Chester St</u>		10f. Zip Code <u>21205</u>	
10g. Citizen of What Country? <u>USA</u>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1yr</u> College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Student</u>		16b. Kind of Business/Industry <u>Barber</u>		17. Father's Name (First, Middle, Last) <u>Eddie L. Williams SR</u>	
18. Mother's Name (First, Middle, Maiden Surname) <u>Pearl Bevel</u>		19a. Informant's Name/Relationship (Type, Print) <u>Betty Lou Williams-wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>927 N. Chester St. 21205 Baltimore, Maryland</u>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Voshell Cemetery</u>		20c. Location - City or Town, State <u>Baltimore, Maryland</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Mullen's Metropolitan Chapel P.C. (Bklyn, MI)</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death)  a. <u>ASTHMA</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>OCME</u>		29d. Date signed (Month, Day, Year) <u>DECEMBER 02, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dennis Chute</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>					
31. Date filed (Month, Day, Year) <u>DEC - 3 2000</u>		32. Registrar's Signature <u>[Signature]</u>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 25 PER MEO G790 12-6-00 WR.

Certificate of Death

Reg. No.

00 38464

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline Zachery</b>				2. Date of Death Month Day Year <b>Nov. 29, 2000</b>				3. Time of Death <b>5:55pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Alice Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>560-60-1966</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-07-35</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		
	Usual Residence of Decedent				10a. State <b>MD</b>				10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>
10e. Street and Number <b>1663 Darley Avenue</b>				10f. Zip Code <b>21213</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>				16b. Kind of Business/Industry <b>Never worked</b>			
17. Father's Name (First, Middle, Last) <b>Alpheus Laws, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Norris</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Harry Deal</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1663 Darley Avenue Baltimore, MD. 21213</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem. 12-04-00 Arbutus, MD</b>				20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Gabriele Cook</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Dua to (or as a consequence of): <b>b. Chronic aspiration</b> Dua to (or as a consequence of): <b>c.</b> Dua to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinsonism</b> <b>Hypertension</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Anil Uberoi MD</b>				29c. License number <b>026748</b>				29d. Date signed (Month, Day, Year) <b>12/1/2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211</b>											
31. Date filed (Month, Day, Year) <b>DEC 5 2000</b>				32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38465

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Barbara Hargrave Burges</b>				2. Date of Death Month <b>November</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>1:15 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>				4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>578-34-8915</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 18, 1927</b>	
9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>15300 Pine Orchard Drive</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Librarian</b>		16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>William Hays Hargrave</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Rachner</b>			
19a. Informant's Name/Relationship (Type, Print) <b>A. Samuel H. Burges/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15300 Pine Orchard Drive, Silver Spring, Maryland 20906</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>November 22, 2000</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>	
21. Signature of Funeral Service Licensee  <b>M00198</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>SEPSIS</b> Due to (or as a consequence of):</p> <p>b. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):</p> <p>c. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of):</p> <p>d. <b>RENAL FAILURE</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>~ 2 DAYS</b></p> <p><b>~ 2 DAYS</b></p> <p><b>~ 6 WEEKS</b></p> <p><b>~ 2 YEARS</b></p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier  <b>Isabella Martire MD</b>				29c. License number <b>A45014</b>		29d. Date signed (Month, Day, Year) <b>November 21/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>3418 OLWOODWOOD COURT OLNEY ISABELLA MARTIRE MD</b>							
31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

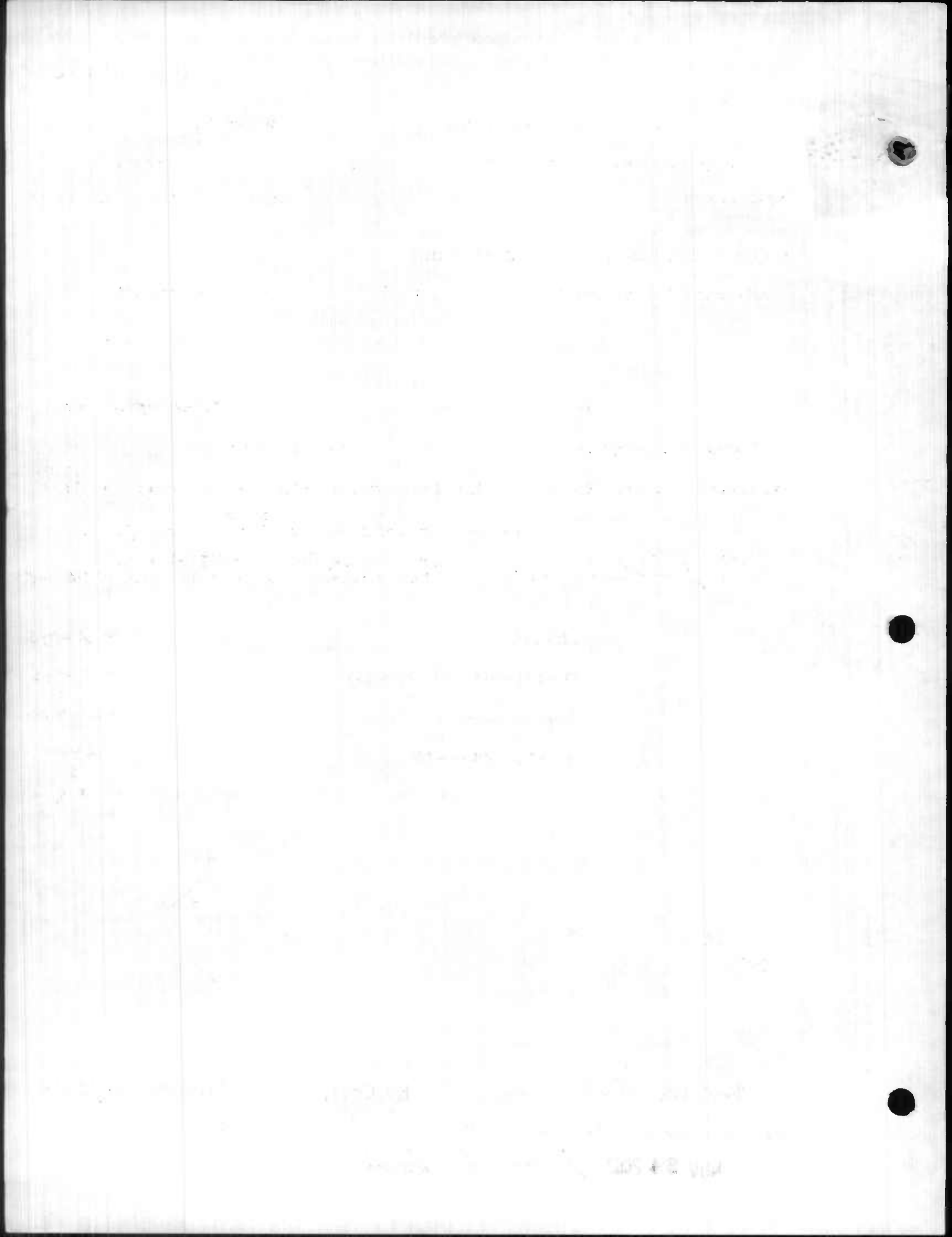
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38466

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WARDELL BROWN</b>				2. Date of Death Month Day Year <b>NOV. 19, 2000</b>		3. Time of Death <b>12:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>237-64-4962</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 24, 1940</b>	
	9. Birthplace (State or Foreign Country) <b>N. Carolina</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2100 Washington Ave., #10D</b>		10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Train Operator</b>		16b. Kind of Business/Industry <b>METRO</b>		17. Father's Name (First, Middle, Last) <b>Wardell Brown, Sr.</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Campbell</b>		19a. Informant's Name/Relationship (Type, Print) <b>Lillie S. Brown (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2100 Washington Ave., Silver Spring, MD 20910</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		20c. Date <b>11/25/00</b>		20d. Location - City or Town, State <b>Silver Spring, MD</b>		21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		
22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CVA</b> Due to (or as a consequence of): b. <b>Diffuse Vascular Disease</b> Due to (or as a consequence of): c. <b>Chronic Renal Failure</b> Due to (or as a consequence of): d. <b>Insulin dependent Diabetes Mellitus</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Kathleen McShane</i>		
29c. License number <b>D16073</b>		29d. Date signed (Month, Day, Year) <b>11/20/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kathleen McShane, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910</b>		31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>		
32. Registrar's Signature <i>B. Sparks</i>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.		

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38467

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emmit Lee Brown				2. Date of Death Month Day Year Nov. 21, 2000		3. Time of Death 6:30 a.m.	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 228-50-1516	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 20, 1940		9. Birthplace (State or Foreign Country) Wash., D.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Montgomery	10c. City, Town or Location Silver Spring, MD			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 1941 Rosemary Hills Dr. #1				10f. Zip Code 20910		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Janitorial			16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) Claude Minor				18. Mother's Name (First, Middle, Maiden Surname) Ida Brown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ingrid Brown/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 Landsdale Burtonsville, MD 20866			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Caroline County VA.		20c. Location - City or Town, State Virginia		20d. Date Nov. 27, 2000	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Dudley Funeral Home 20713 3200 Rhode Island Ave. Mt. Rainier Md.			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death Sudden Days							
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D-32332		29d. Date signed (Month, Day, Year) 11-21-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SK Gubta MD. 9801 Georgia Ave. #220 Silver Spring MD 20902								
31. Date filed (Month, Day, Year) NOV 24 2000				32. Registrar's Signature 				

NOV 3 4 500M



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38468

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRIS BOUTWELL

2. Date of Death  
Month

NOVEMBER

Day

16

Year

2000

3. Time of Death

3:45PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

213-46-7781

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/22/1943

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6105 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

MARK MENSCH

18. Mother's Name (First, Middle, Maiden Surname)

THELMA KARLINSKY

19a. Informant's Name/Relationship (Type, Print)

ALAN MENSCH/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13000 NORTH POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

NOV 19,  
2000

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

P55258

29d. Date signed (Month, Day, Year)

November 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY B. WILKS, MD 6121 Montrose Road Rockville Maryland 20852

31. Date filed (Month, Day, Year)

NOV 20 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38469

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lonnie Dale Bosley				2. Date of Death Month Year NOVEMBER 16, 2000		3. Time of Death 8:50 P.M.		
	4a. Facility Name (If not institution, give street and number) 4710 BETHESDA AVENUE APARTMENT #1510				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 206-54-5807		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 3, 1962		
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4710 Bethesda Avenue #1510		10f. Zip Code 20814		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) William Henry Bosley		18. Mother's Name (First, Middle, Maiden Surname) Roxanne Morrison	
19a. Informant's Name/Relationship (Type, Print) Brenda J. Runner/Ex-wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4710 Bethesda Ave. #1510, Bethesda, Maryland 20814		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland	
21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. MULTIPLE GUNSHOT WOUNDS Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/16/00	
28b. Time of Injury 2051 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT WAS SHOT BY POLICE		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) APT #1510, BETHESDA, MD	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) NOVEMBER 17, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201	
31. Date filed (Month, Day, Year) NOV 20 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38470

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Monica Mary Bernard						2. Date of Death Month Day Year November 18, 2000		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 101-30-4901		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) May 11, 1917		9. Birthplace (State or Foreign Country) England	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1396 Kimblewick Road				10f. Zip Code 20854		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Stanley Brooks				18. Mother's Name (First, Middle, Maiden Surname) Marjorie Bishop					
	19a. Informant's Name/Relationship (Type, Print) Henri J. Bernard/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1396 Kimblewick Road, Rockville, Maryland 20854					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Date Nov. 22, 2000		20d. Location - City or Town, State Bethesda, Maryland			
	21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma Due to (or as a consequence of): Cancer of the Esophagus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Breast Cancer 1986								Approximate Interval Between Onset and Death 6 months 18 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Cancer 1986								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier  M.D.				29c. License number D09470		29d. Date signed (Month, Day, Year) November 19, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895									
	31. Date filed (Month, Day, Year) NOV 24 2000		32. Registrar's Signature 							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 38471

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Selma J Belland</i>				2. Date of Death Month <i>November</i> Day <i>22</i> Year <i>2000</i>		3. Time of Death <i>3:15 am</i>	
	4a. Facility Name (If not institution, give street and number) <i>Solomons Nursing Center</i>				4b. City, Town, or Location of Death <i>Solomons</i>		4c. County of Death <i>Calvert</i>	
Funeral Director	5. Social Security Number <i>578-32-5549</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>94</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>June 22, 1906</i>	9. Birthplace (State or Foreign Country) <i>Minnesota</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Calvert</i>		10c. City, Town or Location <i>Broomes Island</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>9450 River View Road, PO Box 186</i>				10f. Zip Code <i>20615</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Cartographer</i>		16b. Kind of Business/Industry <i>Mapping Industry</i>		
17. Father's Name (First, Middle, Last) <i>Swan Johnson</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Hulda Udd</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Eleanor B. Bower / Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20615</i> <i>9450 River View Road PO Box 186, Broomes Island, MD</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Gate of Heaven Cemetery</i>		Date <i>11/27/00</i>		20c. Location - City or Town, State <i>Silver Spring, MD</i>	
21. Signature of Funeral Service Licensee <i>Robert E. Amney</i>				22. Name and Address of Facility <i>Francis J. Collins Funeral Home, Inc.</i> <i>500 University Blvd., W, Silver Spring, MD 20901</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. SEVERE ALZHEIMER'S DISEASE</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death <i>1 year</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CORONARY ARTERY DISEASE</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dr. A. T. Munshi, MD</i> <i>Attending Physician</i>		29c. License number <i>D19427</i>		29d. Date signed (Month, Day, Year) <i>11/22/2000</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Anwar T. Munshi, MD 110 Hospital Road Suite 303, Prince Frederick, MD 20678</i>								
31. Date filed (Month, Day, Year) <i>NOV 24 2000</i>				32. Registrar's Signature <i>Anwar T. Munshi</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

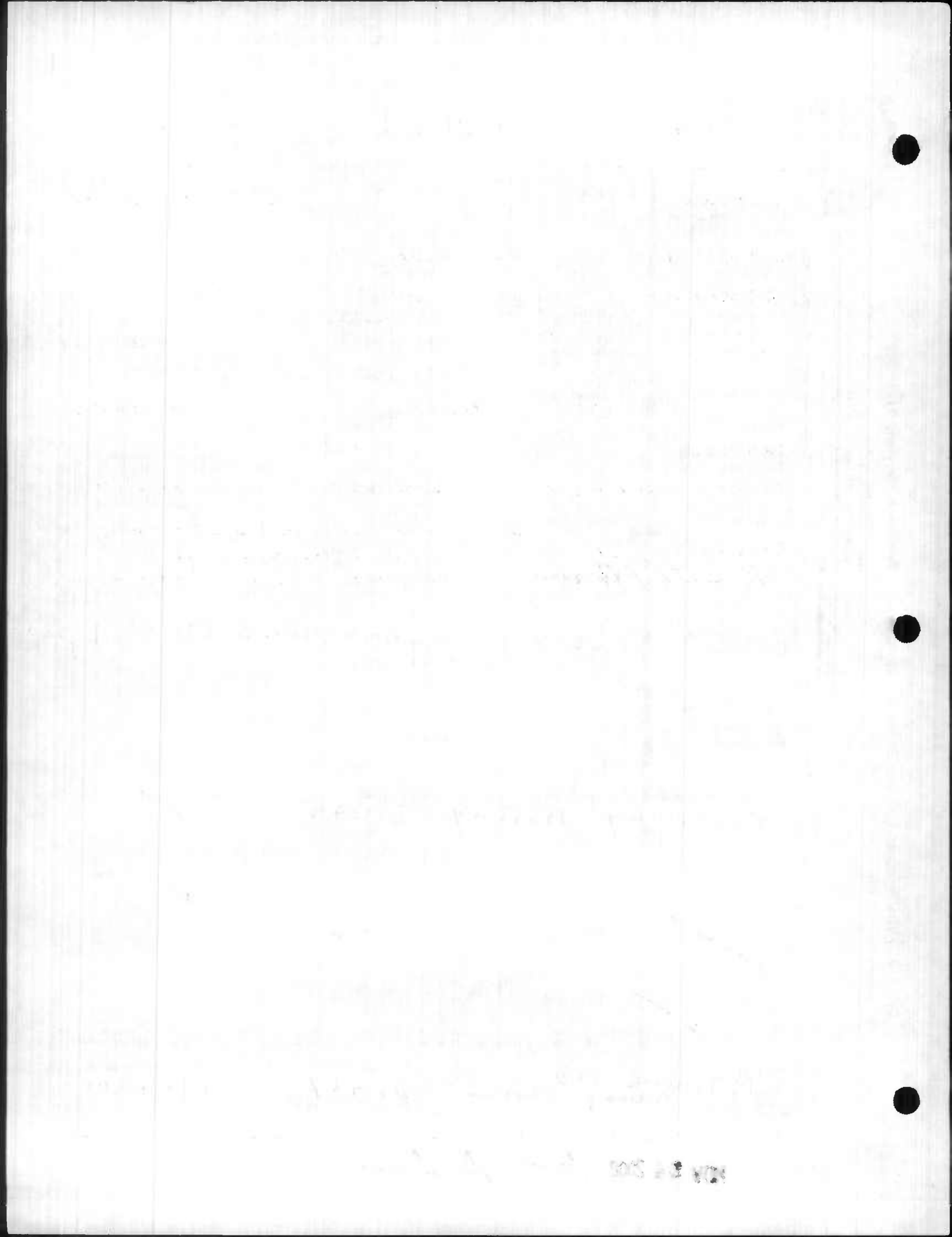
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38472

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John A. Bartolomeo					2. Date of Death Month Day Year November 22, 2000			3. Time of Death 5:10 AM	
	4a. Facility Name (If not institution, give street and number) 5315 Baltimore Avenue					4b. City, Town, or Location of Death Chevy Chase			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-22-2377		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 16, 1923		9. Birthplace (State or Foreign Country) Italy	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5315 Baltimore Avenue				10f. Zip Code 20815		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stock Broker			16b. Kind of Business/Industry Securities		
	17. Father's Name (First, Middle, Last) Nicholangelo Bartolomeo					18. Mother's Name (First, Middle, Maiden Surname) Prudenza DeCarlo				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Theresa Heneghan/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8301 Post Oak Road, Potomac, Maryland 20854					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Nov. 25, 2000		20c. Location - City or Town, State Silver Spring, Maryland			
	21. Signature of Funeral Service Licensee  M00198				22. Name and Address of Facility Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pancreatic Cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Coronary Artery Disease					25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number D0038781		29d. Date signed (Month, Day, Year) November 22, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Grady, M.D. 4910 Massachusetts Avenue, NW, Washington, D.C. 20016										
31. Date filed (Month, Day, Year) NOV 24 2000					32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text at the bottom of the page, possibly a signature or date, followed by the number 1005 20 1981.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38473

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fidel G. Badong

2. Date of Death

November 17, 2000

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

568-92-3356

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 24, 1950

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18131 Chalet Drive #304

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1969-1979

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Edilberto Badong

18. Mother's Name (First, Middle, Maiden Surname)

Raymunda Guerra

19a. Informant's Name/Relationship (Type, Print)

Katherine G. Badong/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18131 Chalet Drive #304, Germantown, Maryland 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

November 22, 2000

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myelogenous Leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myelodysplastic Syndrome

Due to (or as a consequence of):

3 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09470

29d. Date signed (Month, Day, Year)

November 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20+1





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 38474

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gertrude Retta Boone				2. Date of Death Month Day Year November 25 2000				3. Time of Death 05:00	
	4a. Facility Name (If not institution, give street and number) 6858 North Tara Road				4b. City, Town, or Location of Death Federalsburg				4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 215-18-1785		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 6, 1920		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Dorchester		10c. City, Town or Location Federalsburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 6858 North Tara Road				10f. Zip Code 21632	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse Aide				16b. Kind of Business/Industry Nursing				17. Father's Name (First, Middle, Last) Franklin Hilderbrand	
	18. Mother's Name (First, Middle, Maiden Surname) Delphia Folgle				19a. Informant's Name/Relationship (Type, Print) Bessie Berlin/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6858 North Tara Road, Federalsburg, MD 21632	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Anatomy Board				20c. Location - City or Town, State 11/25 Baltimore, MD	
	21. Signature of Funeral Service Licensee Michael F. Eskew				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home Federalsburg, MD 21632				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. pulmonary hypertension Due to (or as a consequence of): b. chronic obstructive lung disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier MD				29c. License number D25750				29d. Date signed (Month, Day, Year) 11/27/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Sanchez 508 Idlewild Easton, MD 21601				31. Date filed (Month, Day, Year) NOV 28 2000				32. Registrar's Signature G. Sparks		

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38475

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Auston Allen Becraft				2. Date of Death Month Day Year November 21 2000				3. Time of Death 1747				
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 577 26 3094		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) December 30, 1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. State Md.		10b. County Montgomery		10c. City, Town or Location Silver Spring				10f. Zip Code 20904				10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-employed				16b. Kind of Business/Industry well digger			
17. Father's Name (First, Middle, Last) Benjamin Becraft						18. Mother's Name (First, Middle, Maiden Surname) Mary Kruhm							
19a. Informant's Name/Relationship (Type, Print) Mary Hardisty/ daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Twin Brook Parkway, Rockville, Maryland 20851							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery		Date 12/1/00		20c. Location - City or Town, State Burtonsville, Md					
21. Signature of Funeral Service Licensee <i>Sevise Dandean</i> M00160				22. Name and Address of Facility Donaldson Funeral Home P.A. 313 Talbott Avenue, Laurel, Maryland 20707									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. SEPTIC SHOCK Due to (or as a consequence of): b. ASCENDING CHOLANGITIS Due to (or as a consequence of): c. CARCINUS CHOLECYSTITIS Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 6 HOURS 8 DAYS 8 DAYS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>Donaldson</i> CRITICAL CARE CONSULTANT				29c. License number D30112				29d. Date signed (Month, Day, Year) NOVEMBER 21 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPENDRA K. SAXENA 15800 Forest Glen RD Silver Spring MD													
31. Date filed (Month, Day, Year) NOV 30 2000				32. Registrar's Signature <i>B. Sparks</i>									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, PER PHY G789 11-18-00 WR.

Certificate of Death

Reg. No.

00 38476

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Theresa Clark</b>				2. Date of Death Month <b>Aug.</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>7:15 p.m.</b>	
	4e. Facility Name (If not institution, give street and number) <b>Mallard Bay Nursing &amp; Rehabilitation</b>				4b. City, Town, or Location of Death <b>Cambridge</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>058-14-8966</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 13, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Cambridge</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>The Bradford House 701 Race St., Apt. 118</b>		10f. Zip Code <b>21613</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
	17. Father's Name (First, Middle, Last) <b>Robert Meehan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen (maiden name unknown)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Divers H. Childers/P.R.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Mimosa Dr., Cambridge, MD 21613</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Downing Cemetery</b>		20c. Location - City or Town, State <b>Unknown Oak Hall, VA</b>			
	21. Signature of Funeral Service Licensee <i>Curran-Bromwell</i>		22. Name and Address of Facility <b>Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>myocardial infarction</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. <b>Hypertensive Cardiovascular disease</b> Due to (or as a consequence of): <b>STATUS POST HIP FIXATION</b> d. <b>Hip fracture</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>Amr</i>				29c. License number <b>D 50987</b>		29d. Date signed (Month, Day, Year) <b>8-24-00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Ahmed NAWAZ 300 Anson Street Cambridge MD 21613</b>							
31. Date filed (Month, Day, Year) <b>AUG 25 2000</b>				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHHM 16 Rev 6/95

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Schwarz" and "Licht" are visible.

Handwritten signature or name, possibly "Friedrich Schlegel".

11

Handwritten text at the bottom, possibly "Königliche Bibliothek".



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38477

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel O'Brien Coyle

2. Date of Death

November 19, 2000

3. Time of Death

4:00 am

4a. Facility Name (If not institution, give street and number)

Bedford Court Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

560-26-1314

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 22, 1911

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3700 International Drive, Room 162

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Gordon O'Brien

18. Mother's Name (First, Middle, Maiden Surname)

Sadie McKay

19a. Informant's Name/Relationship (Type, Print)

Anne Coyle/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3001 Veazey Terrace, NW, Washington, DC 20008

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Point Cemetery

Date

11/28/00 West Point, NY

20c. Location - City or Town, State

21. Signature of Funeral Service Licentiate

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

5 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Paroxysmal Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be determined ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 31918

29d. Date signed (Month, Day, Year)

November 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Warren Ferris, MD 3305 North Leisure World Blvd., Silver Spring, MD

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38478

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles Randall Conabee</b>				2. Date of Death Month Day Year <b>Nov. 20 2000</b>		3. Time of Death <b>9:15 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>7701 Mary Cassatt Dr.</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>184 18 9079</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 19, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Potomac</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>7701 Mary Cassatt Dr.</b>		10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronics Engineer</b>		16b. Kind of Business/Industry <b>Private Industry</b>		17. Father's Name (First, Middle, Last) <b>Charles Ralston Conabee</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Genevra Beggs</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mary S. Conabee / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7701 Mary Cassatt Dr.; Potomac, MD 20854</b>		20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc.</b>		20c. Date <b>Nov. 25 2000</b>		20d. Location - City or Town, State <b>Beltsville, MD</b>		21. Signature of Funeral Service Licensed <b>Stephen D. Lohrmann</b>	
	22. Name and Address of Facility <b>Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 20910</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Idiopathic pulmonary fibrosis</b> Due to (or as a consequence of): <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		Approximate Interval Between Onset and Death <b>1 Year</b>	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Rectal Carcinoma</b> <b>Osteomyelitis</b>		24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		25. Was case referred to medical examiner? <b>1 Yes 2 No</b>	
	26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>	
	29b. Signature and title of certifier <b>Dr. Martin S. Kanovsky</b>		29c. License number <b>D29229</b>		29d. Date signed (Month, Day, Year) <b>11/22/2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Martin S. Kanovsky, M.D.; 5530 Wisconsin Ave., Chevy Chase, Maryland 20815</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>		32. Registrar's Signature <b>B. Spots</b>					



00 38479

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38480

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alan Brian Claflin</b>					2. Date of Death Month Day Year <b>Nov. 21, 2000</b>		3. Time of Death <b>12:05 PM.</b>			
	4a. Facility Name (If not institution, give street and number) <b>2285 Dunster Lane</b>					4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>			
Funeral Director	5. Social Security Number <b>212-34-3855</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jun. 16, 1934</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC.</b>		
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>2285 Dunster Lane</b>					10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>D O E (Dept. Of Energy)</b>			16b. Kind of Business/Industry <b>US Government</b>			
	17. Father's Name (First, Middle, Last) <b>Frederick Fremont Claflin</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Dorothy Cave</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Cynthia Claflin - Wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2285 Dunster Lane, Rockville, Md. 20854</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>West Point Military Cem.</b>			20c. Date <b>11/29</b>		20d. Location - City or Town, State <b>West Point, NY</b>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Nancy A. P... ..</b>					22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Pancreatic Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 years</b>		
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <b>George A. Sotos</b>		29c. License number <b>D43083</b>		29d. Date signed (Month, Day, Year) <b>Nov. 22, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George A. Sotos, MD. 9707 Medical Center Dr. #300, Rockville, Md. 20850</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>					32. Registrar's Signature <b>Geneva B. Sparks</b>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38481

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clementina Cicala		2. Date of Death Month Day Year Nov. 20, 2000		3. Time of Death 1:15 PM
	4a. Facility Name (If not institution, give street and number) Casey House		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 577-44-7055	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 26, 1911	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State none	10b. County none	10c. City, Town or Location Washington, DC		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 4217 Ingomar St., NW		10f. Zip Code 20015		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. Kind of Business/Industry Clothing Business
	17. Father's Name (First, Middle, Last) Carmelo Puglisi		18. Mother's Name (First, Middle, Maiden Surname) Grazia DeLuca		
	19a. Informant's Name/Relationship (Type, Print) Guiseppe A. Cicala/son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4227 Ingomar St., NW., Washington, D.C. 20015		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Nov. 24, 00 Silver Spring, Md.
	21. Signature of Funeral Service Licensee John F. DeVol		22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, D.C. 20007		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma Due to (or as a consequence of): b. Adenocarcinoma of unknown primary Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Venous Thrombosis				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier E. P. Libre M.D.					
29c. License number D09470					
29d. Date signed (Month, Day, Year) Nov. 20, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D., 10400 Connecticut Ave., Kensington, Md. 20895					
31. Date filed (Month, Day, Year) NOV 22 2000					
32. Registrar's Signature P. [Signature]					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38482

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty M. Cawley

2. Date of Death

November 22, 2000

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-18-1201

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

8. Date of Birth (Month, Day, Year)

October 17, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1609 Green Spring Drive

10f. Zip Code

21093

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Medical Lab

17. Father's Name (First, Middle, Last)

John Martin

18. Mother's Name (First, Middle, Maiden Surname)

Emma Mathias

19a. Informant's Name/Relationship (Type, Print)

George W. Cawley / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1609 Greenspring Dr., Lutherville, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc

Date

11/24/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Laura C. Hardesty

22. Name and Address of Facility

CAFA Stephen D. Lohrmann, P.A.  
8717 Green Pastures DR., Towson, MD 21286Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUBDURAL HEMATOMA

Due to (or as a consequence of):

b. END STAGE PARKINSON'S DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tariq

29c. License number

D43725

29d. Date signed (Month, Day, Year)

11/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 24 2000

32. Registrar's Signature

B. Sparks

NOVEMBER 22, 2000 3:30 a.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BETTY CAWLEY







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38483

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paul H. Carter</b>		2. Date of Death Month Day Year <b>NOV. 16, 2000</b>		3. Time of Death <b>0935 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>854 COLLEGE PARKWAY, T-2</b>		4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>217-30-0976</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 3, 1936</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>3312 Chiswick Court</b>			10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Firefighter</b>		16b. Kind of Business/Industry <b>Fire Department</b>	
17. Father's Name (First, Middle, Last) <b>James Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Liskey</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sara Trevey/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7932 Mapleville Road, Boonsboro, Maryland 21713</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>November 20, 2000</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>
21. Signature of Funeral Service Licensee  <b>M00198</b>			22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONTACT GUN SHOT WOUND OF HEAD</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <b>PARTIAL</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>11/16/00</b>		28b. Time of Injury <b>FOUND 0930 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred <b>SUBJECT SHOT SELF</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>A RESIDENCE</b>				
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>854 COLLEGE PARKWAY, T2, ROCKVILLE, M.D.</b>						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier  <b>Paul H. Carter</b>			29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>NOV. 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPPY 111 Penn Street, Baltimore, Maryland 21201</b>						
31. Date filed (Month, Day, Year) <b>NOV 20 2000</b>		32. Registrar's Signature  <b>B. Smith</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

Reg. No.

00 38484

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beverly A. Carter				2. Date of Death Month Day Year NOV. 16, 2000		3. Time of Death 0935 AM	
	4a. Facility Name (If not institution, give street and number) 854 COLLEGE PARKWAY, T-2				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 218-34-5807		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) April 2, 1936	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 643 Azalea Drive		10f. Zip Code 20850		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant		16b. Kind of Business/Industry Heating & Air Conditioning Company			
	17. Father's Name (First, Middle, Last) Louis G. Mitchell				18. Mother's Name (First, Middle, Maiden Surname) Irma Beall			
	19a. Informant's Name/Relationship (Type, Print) Sara Trevey/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7932 Mapleville Road, Boonsboro, Maryland 21713			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Data Nov. 19, 2000		20c. Location - City or Town, State Bethesda, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <u>MULTIPLE GUN SHOT WOUNDS</u> Due to (or as a consequence of):					
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11/16/00		28b. Time of Injury 0930 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred SUBJECT WAS SHOT		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT RESIDENCE		28f. Location (Street and Number or Rural Route Number, City or Town, State) 854 COLLEGE PARKWAY, T-2, ROCKVILLE, MD.			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) NOV. 17, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) NOV 20 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



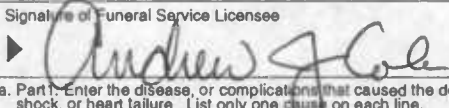

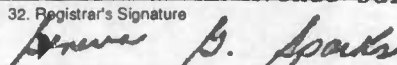
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38485

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William M. Carrigan</b>				2. Date of Death Month Day Year <b>November 20, 2000</b>				3. Time of Death <b>1:50 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>9615 West Stanhope Road</b>				4b. City, Town, or Location of Death <b>Kensington</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-60-3276</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 10, 1902</b>		9. Birthplace (State or Foreign Country) <b>Iowa</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Kensington</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>9615 West Stanhope Road</b>				10f. Zip Code <b>20895</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Industrial Developer</b>				16b. Kind of Business/Industry <b>Commercial Properties</b>		
17. Father's Name (First, Middle, Last) <b>Michael Patrick Carrigan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary McGuire</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Charles E. Furr/ Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1585 Uluhao Street, Kailua, HI 96734</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery</b>		Date <b>11/30/00</b>		20c. Location - City or Town, State <b>Washington, DC</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Acute Myocardial Infarct</b> Due to (or as a consequence of):  b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death  1 hour  5 years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number <b>D 04179</b>				29d. Date signed (Month, Day, Year) <b>November 22, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James J. Foster, MD 5530 Wisconsin Avenue Suite 925, Chevy Chase, MD 20815</b>										
31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38486

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA J. CAMPBELL

2. Date of Death

Month Day Year  
NOV. 16, 2000

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-54-1837

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 3, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17060 King James Way, #308

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Henry Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Eliza Sewell

19a. Informant's Name/Relationship (Type, Print)

Virgie M. Thompson (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

516 Bickford Lane, Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Park Cem.

Date

11/22/00

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

246 N. Wash. St., Rockville, MD 20850

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

b. Myocardial Infarction - Acute

Due to (or as a consequence of):

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Atherosclerosis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

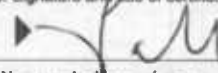
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D56652

29d. Date signed (Month, Day, Year)

Nov. 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW POFFENROTH MD

809 VIER'S MILL RD  
ROCKVILLE, MD 20851

31. Date filed (Month, Day, Year)

NOV 21 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-328-2000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner




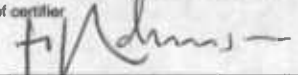

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38487

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Elwood CASLOW				2. Date of Death Month Nov. 12, Day 2000 Year		3. Time of Death 8:50 AM										
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett										
Funeral Director	5. Social Security Number 577-24-9571		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) May 12, 1920										
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland										
Usual Residence of Decedent																	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
10e. Street and Number 59 Sangamore Drive				10f. Zip Code 21550		10g. Citizen of What Country? USA											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 10th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenanceceman		16b. Kind of Business/Industry Gardening Center											
17. Father's Name (First, Middle, Last) Joseph Samuel Caslow				18. Mother's Name (First, Middle, Maiden Surname) Catherine L. Lowe													
19a. Informant's Name/Relationship (Type, Print) Elizabeth J. Caslow/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Sangamore Drive, Oakland, Md. 21550													
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Md. Vet. Cem.		20c. Date 11/14/00		20d. Location - City or Town, State Flintstone, Md.										
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550													
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. Pneumonia</td> <td>Approximate Interval Between Onset and Death 1 Week</td> </tr> <tr> <td>b. COPD</td> <td>Years</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonia	Approximate Interval Between Onset and Death 1 Week	b. COPD	Years	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonia	Approximate Interval Between Onset and Death 1 Week															
	b. COPD	Years															
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASHD																	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) 4 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier 				29c. License number D15333		29d. Date signed (Month, Day, Year) 11/13/00											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550																	
31. Date filed (Month, Day, Year) NOV 14 2000				32. Registrar's Signature 													



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38488

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Katherine Christian

2. Date of Death

November 28, 2000

3. Time of Death

7:55PM

4a. Facility Name (If not institution, give street and number)

6315 Sandy Street

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

219-34-7932

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 24, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6315 Sandy Street

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Electronics Components

17. Father's Name (First, Middle, Last)

Gordon Sullivan

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Barnes

19a. Informant's Name/Relationship (Type, Print)

Gail Veitch/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6315 Sandy Street, Laurel, Maryland 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

Dec. 2, 2000

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Janice Hallett MO1103

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Avenue, Laurel, MD 20707

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC RENAL CELL CARCINOMA

Approximate Interval Between Onset and Death

MONTHS

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, MIXED CONNECTIVE TISSUE DISEASE

CHRONIC ANEMIA, PANCYTOPEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Janice Hallett

29c. License number

D24035

29d. Date signed (Month, Day, Year)

11/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F. MACHADO 321 PRINCE GEORGE ST LAUREL MD 20723

31. Date filed (Month, Day, Year)

NOV 30 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38489

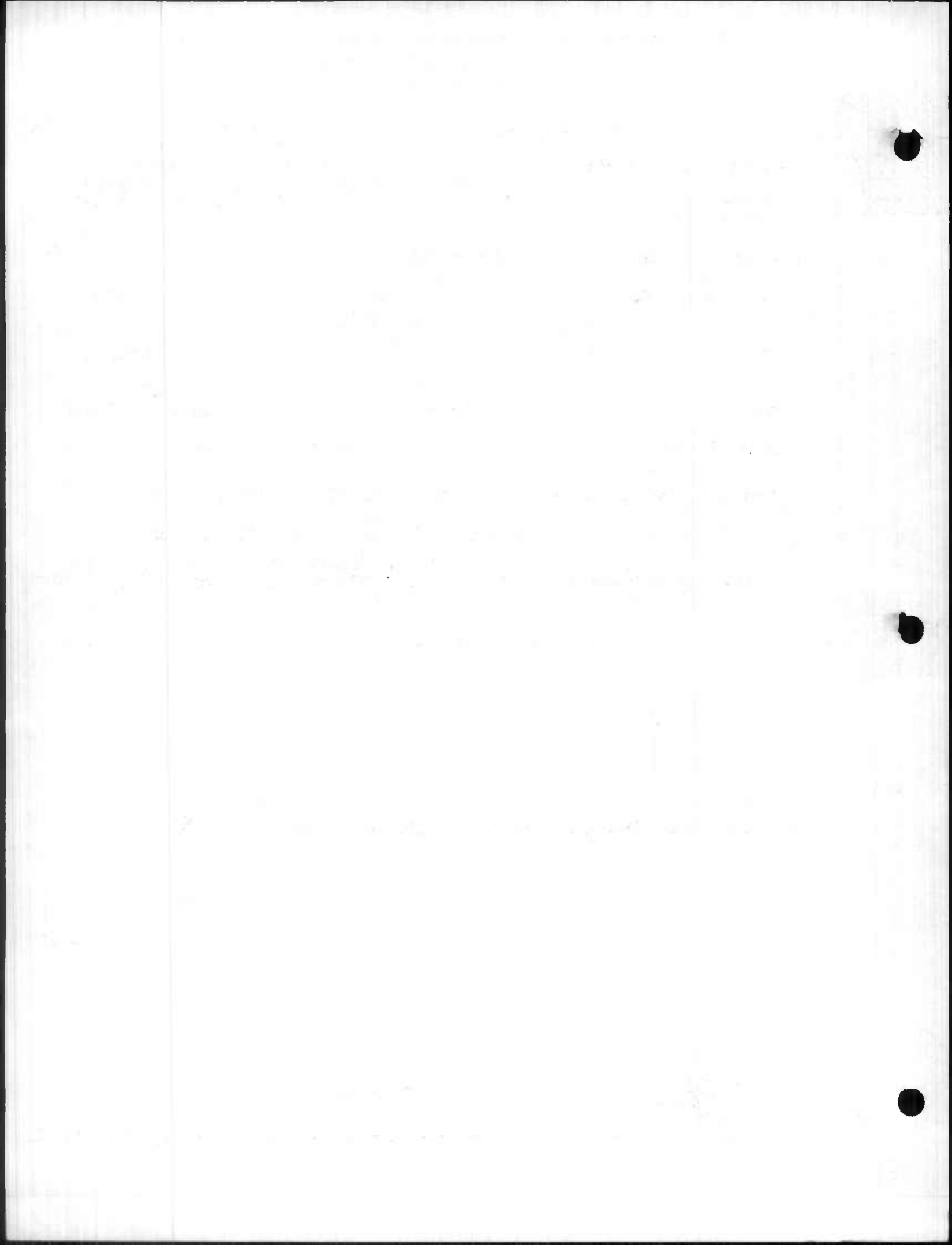
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace W. Colburn				2. Date of Death Month Day Year November 22 2000		3. Time of Death 1:30 PM	
	4e. Facility Name (If not institution, give street and number) Sunrise Assisted Living				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 218-01-8264	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 10, 1909	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State Maryland	10b. County Howard	10c. City, Town or Location Ellicott City			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 2509 Melba Rd.			10f. Zip Code 21042		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry B.G.&E Martin Marietta			
	17. Father's Name (First, Middle, Last) Harry N. Welsh				18. Mother's Name (First, Middle, Maiden Surname) Maggie M. Smith			
	19a. Informant's Name/Relationship (Type, Print) Dorothy W. Phelps / sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Melba Rd. Ellicott City, MD. 21042				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Cem.		20c. Location - City or Town, State 11-27-2000 Timonium, MD			
	21. Signature of Funeral Service Licensee Sharon A. Collins-Witzke				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ALZHEIMER'S DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, PARKINSON'S DISEASE, RENAL INSUFFICIENCY						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) asst lving						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number D38296		29d. Date signed (Month, Day, Year) Nov 24, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELICOTT CITY, MD 21042								
31. Date filed (Month, Day, Year) NOV 27 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38490

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Claudia Joyce Collins

2. Date of Death  
Month Day Year  
November 23, 20003. Time of Death  
5:40 pm

4a. Facility Name (If not institution, give street and number)

2195 Blacks Schoolhouse Rd.

4b. City, Town, or Location of Death

Taneytown

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

219-38-4732

6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
58 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
April 25, 19429. Birthplace (State or Foreign  
Country)  
North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Taneytown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2195 Blacks Schoolhouse Rd.

10f. Zip Code

21787

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman Burnell Whitehurst

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Gardner

19a. Informant's Name/Relationship (Type, Print)

Dennis Collins / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2195 Blacks Schoolhouse Rd. Taneytown, MD. 21787

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crestlawn Memorial Gard.

Date

Nov. 27

20c. Location - City or Town, State

Marriottsville, MD.

21. Signature of Funeral Service Licensee

Dennis Collins - Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD. 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hepatic failure

Due to (or as a consequence of):

b. Cryptogenic cirrhosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Coronary artery disease

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Howard G. Lanham

29c. License number

D17040

29d. Date signed (Month, Day, Year)

November 27, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Howard G. Lanham, M.D. 215 Washington Hgts Med Ctr, Westminster, MD

31. Date filed (Month, Day, Year)

NOV 27 2000

32. Registrar's Signature

B. Sparks

21157

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38491

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cherie Cook</b>				2. Date of Death Month <b>Nov.</b> Day <b>22</b> Year <b>2000</b>				3. Time of Death <b>8:45pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>None</b>		
Funeral Director	5. Social Security Number <b>218-68-1177</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/04/55</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>3134-C West Springs Drive</b>				10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Paul S. Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jean S. Fleming</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Wendy Martin-Walther/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1816 Daisy Road Woodbine, MD 21797</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			20c. Location - City or Town, State <b>11-24-2000 Catonsville, MD</b>				
21. Signature of Funeral Service Licensee <b>Shirley Collins-Walther</b>				22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>esophageal varicities - bleeding</b> Due to (or as a consequence of): b. <b>hepatic failure</b> Due to (or as a consequence of): c. <b>hepatic encephalopathy</b> Due to (or as a consequence of): d. <b>alcohol abuse</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>20 days</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Julia A. Presti DO</b>				29c. License number <b>RES 00000</b>		29d. Date signed (Month, Day, Year) <b>11/22/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Julia Presti DO University Medical System Baltimore MD 21201</b>											
31. Date filed (Month, Day, Year) <b>NOV 27 2000</b>				32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38492

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN

DYRKACZ

2. Date of Death

Month  
NOV.

Day

18,

Year

2000

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

ROCKVILLE NURSING HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

176-09-5787

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 21, 1915

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15422 BRAMBLEWOOD DR.

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NATIONAL SECURITY AGENT

16b. Kind of Business/Industry

N.S.A. FED. GOV'T.

17. Father's Name (First, Middle, Last)

ELIAS

DYRKACZ

18. Mother's Name (First, Middle, Maiden Surname)

STELLA

ANASTASIA

SABRAM

19a. Informant's Name/Relationship (Type, Print)

JOHN A. DYRKACZ/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 ELK RUN CT., OAK RIDGE, N.C. 27310

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

11/21/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

cerebrovascular accident

b. Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Elliot R. Goldstein

29c. License number

D03581

29d. Date signed (Month, Day, Year)

NOVEMBER 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELLIOT R. GOLDSTEIN, M.D.

9410 OLD GEORGETOWN RD., BETHESDA, MD. 20814

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 22 2000

32. Registrar's Signature

B. Spade

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

9+1

NOES 2 8 YOW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38493

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry W. Dunn

2. Date of Death

November 17, 2000

3. Time of Death

5:24 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

461-32-4909

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1924

9. Birthplace (State or Foreign Country)

Colorado

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3650 Daisy Road

10f. Zip Code

21797

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1945-  
194613. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Norman Dunn

18. Mother's Name (First, Middle, Maiden Surname)

Floy Baker

19a. Informant's Name/Relationship (Type, Print)

Millicent H. Dunn / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3650 Daisy Road, Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

George Washington Cemetery

Date  
11/22

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

James S. Dooly

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock or heart failure. List only one cause of death line.Immediate Cause (Final  
disease or condition  
resulting in death)

ACUTE MYOCARDIAL INFARCTION TERM

Due to (or as a consequence of):

CORONARY HEART DISEASE 10 YRS

Due to (or as a consequence of):

ARTERIOSCLEROTIC CARDIOVASCULAR DIS 10 YRS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Donald R. Lewis MD

29c. License number

DO 6406

29d. Date signed (Month, Day, Year)

NOVEMBER 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD 4000 RT 108 OLNEY, MARYLAND 20832

31. Date filed (Month, Day, Year)

NOV 20 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

CLEAR BY M.E.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38494

Amend #7, 11/21/00, GF, Montg. Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH E DONOHUE				2. Date of Death Month Day Year NOVEMBER 16, 2000		3. Time of Death 10:20 AM		
	4a. Facility Name (If not institution, give street and number) Collington Episcopal Life Care Center				4b. City, Town, or Location of Death Mitchellville		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 507-14-8117		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 88 Yrs.		8. Date of Birth (Month, Day, Year) Sept 30, 1912		
	9. Birthplace (State or Foreign Country) Nebraska		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10450 Lottsford Road		10f. Zip Code 20712		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Administrative/ NSA		16b. Kind of Business/Industry Federal Government					
17. Father's Name (First, Middle, Last) Arthur Latham				18. Mother's Name (First, Middle, Maiden Surname) Jenny B. Smith					
19a. Informant's Name/Relationship (Type, Print) Richard Whelton / Guardian				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13629 Baltimore Road, Laurel, MD 20707					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park		20c. Location - City or Town, State 11/21/00 Falls Church, VA					
21. Signature of Funeral Service Licensee Robert P. Spinks				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 5+ YRS Due to (or as a consequence of): b. CEREBROVASCULAR DISEASE 5+ YRS Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Jeffrey Kelaman, MD				29c. License number D 20391		29d. Date signed (Month, Day, Year) November 17, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Kelaman, MD 10450 Lottsford Road, Mitchellville, MD									
31. Date filed (Month, Day, Year) NOV 21 2000				32. Registrar's Signature Anna B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38495

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leona Alice DeMuth

2. Date of Death

November 20, 2000

3. Time of Death

7:20 pm

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice- Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

030-12-6642

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 11, 1922

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3113 Parker Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Norton Barney

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Anderson

19a. Informant's Name/Relationship (Type, Print)

Francis J. DeMuth / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3113 Parker Avenue, Wheaton, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 11/25/00 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John Z. Chyl

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W. Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Scleroderma

months

Due to (or as a consequence of):

b. Gangrene lower extremities

months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph Kaplan

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

November 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, MD 18111 Prince Philip Drive, Olney, MD 20832

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 22 2000

32. Registrar's Signature

B. Kaplan

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 38496

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jeanette C. Dolby</b>				2. Date of Death Month <b>Nov.</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>12:50PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>101 Wrights Avenue</b>				4b. City, Town, or Location of Death <b>Hurlock</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>213-03-9822</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 18, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Delaware</b>		10a. State <b>MD</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>Hurlock</b>	
10d. Instate City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>101 Wrights Avenue</b>		10f. Zip Code <b>21643</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Victor Reed</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Dahlis</b>		19a. Informant's Name/Relationship (Type, Print) <b>Sherry Dolby/Granddaughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6743 East New Market-Elwood RD. Hurlock, MD 21643</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Unity-Washington Cem.</b>		20c. Date <b>11/24</b>		20d. Location - City or Town, State <b>Hurlock, Maryland</b>		21. Signature of Funeral Service Licensee <b>Christine M. Coale</b>		
22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colorectal Cancer</b>		23b. Approximate Interval Between Onset and Death <b>6 yrs</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		25b. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		25c. Date of injury (Month, Day Year) <b>11/27/00</b>		25d. Time of injury <b>M</b>		
25e. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25f. Describe how injury occurred		25g. Location (Street and Number or Rural Route Number, City or Town, State)		25h. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
25i. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		25j. Date of death (Month, Day Year) <b>NOV 28 2000</b>		25k. Registrar's Signature <b>B. Sparks</b>		25l. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Falken MD 302 Collins Ave Hurlock md 21643</b>		

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 38497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCE CORLEY DUNN

2. Date of Death

Month Day Year  
NOVEMBER 16 2000

3. Time of Death

2:19 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

5. Social Security Number

235-24-2640

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 1, 1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

W. Va.

10b. County

Randolph

10c. City, Town or Location

Elkins

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11 Dent Street

10f. Zip Code

26241

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Burr Freeman Corley

18. Mother's Name (First, Middle, Maiden Surname)

Rose Lee Hess

19a. Informant's Name/Relationship (Type, Print)

Hobert Corley, Sr/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

50 Locust Street, Elkins, WV 26241

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mausoleum

Date

11/20/00

20c. Location - City or Town, State

Elkins, WV

21. Signature of Funeral Service Licensee

Robert A. Myers

22. Name and Address of Facility

Myers Funeral Home

91 Willis Street

Westminster, MD

21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

TWO DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BILATERAL PNEUMONIA

Due to (or as a consequence of):

TWO DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEFT UPPER LOBE CAVITARY LESION.

CONGESTIVE HEART FAILURE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sumeet Sawhney

29c. License number

P-14121.

29d. Date signed (Month, Day, Year)

NOVEMBER 16 2000.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUMEET SAWHNEY 3001 S. HANOVER ST, HARBOR HOSPITAL CENTER

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 20 2000

32. Registrar's Signature

Denise Sparks

FLORENCE LUCILLE DUNN-CAPPADONY

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38498

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRA LUVENA DETERMAN				2. Date of Death Month Day Year October 25 2000		3. Time of Death 10:50 P			
	4a. Facility Name (If not institution, give street and number) Levindale Nursing Facility				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City			
Funeral Director	5. Social Security Number 220 26 9408		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Oct 31 1929			
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Md.		10b. County Allegany		10c. City, Town or Location Westernport			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 120 Church St.		10f. Zip Code 21562			
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) George Edison Bever				18. Mother's Name (First, Middle, Maiden Surname) Edith Elizabeth Fox					
	19a. Informant's Name/Relationship (Type, Print) Joseph E. Determan/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Church St., Westernport, Md. 21562					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cem.		20c. Location - City or Town, State 10 28 00 Westernport, Md.			
	21. Signature of Funeral Service Licensee F. Wayne Bond				22. Name and Address of Facility Boal Funeral Home 111 Church St. Westernport, Md.					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Non-Small Cell Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Debra S. Wertheimer MD				29c. License number D23767		29d. Date signed (Month, Day, Year) October 25, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debra S. Wertheimer MD, 2434 W. Belvedere Ave, Baltimore, Md 21215									
	31. Date filed (Month, Day, Year) NOV - 8 2000				32. Registrar's Signature B. [Signature]					

THE UNIVERSITY OF CHICAGO  
LIBRARY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38499

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVERETT GENE EYE

2. Date of Death

Nov 21, 2000

3. Time of Death

~ 5 PM

4a. Facility Name (If not institution, give street and number)

7519 Greenwood Drive

4b. City, Town, or Location of Death

Highland

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

165-30-8839

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 19, 1938

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Highland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7519 Greenwood Drive

10f. Zip Code

20777

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Arvil Eye

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Baugher

19a. Informant's Name/Relationship (Type, Print)

Karen Diane Eye/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7519 Greenwood Drive, Highland, MD 20777

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

11/24/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

J. L. Chappell

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gunshot Wound to Head

Due to (or as a consequence of):

seconds

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Depression - Major

Due to (or as a consequence of):

5-6 wks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)  
Nov 21/00

28b. Time of Injury

~ 5 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self inflicted GSW to head

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

S/A. (10 a-f)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patricia A. Toye, MD ME Deputy

29c. License number

D31473

29d. Date signed (Month, Day, Year)

Nov 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA A. TOYE, MD 4565 HENLOCK COUNTRYWAY ELICOTT CITY, MD 21042

State  
Registrar

31. Date filed (Month, Day, Year)

NOV 24 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 38500

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret L. Elliott</b>				2. Date of Death Month <b>November</b> Day <b>21</b> Year <b>2000</b>		3. Time of Death <b>9:25 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>3817 Gawayne Terrace</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>215-38-4397</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>September 23, 1918</b>		
	10e. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3817 Gawayne Terrace</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>England</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Appraiser</b>			16b. Kind of Business/Industry <b>Real Estate</b>		
17. Father's Name (First, Middle, Last) <b>Charles Street</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Edwards</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen P. Chiacchio/ Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3053 Hickorymede Drive Ellicott City, Maryland 21042</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>			
21. Signature of Funeral Service Licensee  <b>M00335</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):								<b>2 weeks</b>	
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Stroke</b> Due to (or as a consequence of):								<b>2 weeks</b>	
Due to (or as a consequence of):									
Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>D 39190</b>		29d. Date signed (Month, Day, Year) <b>November 21, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Joseph Garrett Reilly, M.D. 11510 Old Georgetown Road, Rockville, Maryland 20852</b>									
31. Date filed (Month, Day, Year) <b>NOV 24 2000</b>				32. Registrar's Signature 					

ORIGINAL

